

DHMM - 16 50M 1/81
(VRA 15, 4)

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 82 07274			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph SPENCER ACKINSON SR.				2b. DATE OF DEATH MONTH DAY YEAR HOUR March 23 1982 9 ¹⁰ PM			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR APR. 13, 1923		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 58	
7a. BIRTHPLACE (COUNTRY) STATE OR FOREIGN MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Forklift Operator		12b. KIND OF BUSINESS OR INDUSTRY retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 273 Wilson St.		14. FATHER'S NAME FIRST MIDDLE LAST ALBERT ACKINSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SADIE ELLIOTT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 220-14-8768		17. INFORMANT THE MARY A. ACKINSON - SAME		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1519 MALNUTRITION DUE TO, OR AS A CONSEQUENCE OF (b) GASTRIC OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC GASTRIC CARCINOMA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH - 3 mos - - 3 mos - 18 mos			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
22a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22b. PLACE OF INJURY (AT HOME, STREET, PARK, OFFICE, FARM, ETC.)		22c. LOCATION CITY OR TOWN COUNTY STATE			
22d. I certify that (I) (this hospital) attended the deceased from 3-23 1982 to 3-23 1982 that (I) (we) last saw the deceased alive on 3-23 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22e. SIGNATURE A. P. CANLAS, M.D.				DEGREE		22f. DATE SIGNED 3/24/82	
22g. PHYSICIAN'S NAME (TYPE OR PRINT)				22h. ADDRESS 504 LEWIS ST. HAVRE DE GRACE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAR. 27, 82		23c. NAME OF CEMETERY OR CREMATORY HARFORD MEMORIAL GARDENS		23d. LOCATION CITY OR TOWN COUNTY STATE HARFORD MD.	
24. FUNERAL DIRECTOR MITCHELL E.H. P.A. HAVRE DE GRACE, MD.				25a. DATE REC'D. BY REGISTRAR MAR 26 1982		25b. REGISTRAR'S SIGNATURE Anne J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M7/77
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) Okley M. Age					2a. DATE OF DEATH MONTH DAY YEAR March 11, 1982			2b. HOUR M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 12, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.						
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder		12b. KIND OF BUSINESS OR INDUSTRY Shipbuilding				
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Darlington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3314 Hughes Road				
14. FATHER'S NAME FIRST MIDDLE LAST James H. Age					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lutishey Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 233-10-5930		17. INFORMANT ADDRESS Grace S. Age, 3314 Hughes Rd., Darlington, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Arteriosclerosis</u> 4110 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio Vascular disease & Coronary</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Muscle weakness, Copd, Asthmatic Bronchitis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 YRS		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 1950</u> to <u>MARCH 11, 1982</u> , that (I) (we) last saw the deceased alive on <u>2:30pm 3/11 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Dudley Phillips MD</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>3/11/82</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dudley Phillips MD</u>				22e. ADDRESS <u>Bx300 Darlington Md 21034</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/14/82		23c. NAME OF CEMETERY OR CREMATORY Dublin Missionary Baptist Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Dublin, Harford Co., Md.		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>	
24. FUNERAL DIRECTOR NAME John H. Harkins, 600 Main St., Delta, Pa.				ADDRESS				25a. DATE REC'D. BY REGISTRAR MAR 16 1982				

BP

NO. 1

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 82 07276			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Florence Edith Aldrich				2b. HOUR 11:10 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 16, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1018 JAMES STREET		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
13a. STATE Maryland				13b. COUNTY Harford Co.		13c. CITY OR TOWN Bel Air	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Daugherty				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Singleton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO 217-22-0636		17. INFORMANT (Daughter) 838-4757 ADDRESS Mrs. Louise E. Daughton 1018 JAMES STREET Bel Air, Maryland 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-RESP. FAILURE</u> <u>4292</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>A.S.C.U.D.</u> (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u> <u>10 YRS</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>MAR</u> , 19 <u>70</u> , to <u>MAR</u> , 19 <u>72</u> , that (I) (we) lost saw the deceased alive on <u>23 FEB</u> , 19 <u>82</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did not (did not) view the body after death.							
22b. SIGNATURE <u>H.P. Sidwell</u> M.D.				DEGREE M.D.		22c. DATE SIGNED March 28, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.P. SIDWELL M.D.				22e. ADDRESS 401 Franklin St., Bel Air, Maryland 21014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 30, 1982		23c. NAME OF CEMETERY OR CREMATORY Jarrettsville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Jarrettsville Harford Co., Maryland 21084	
24. FUNERAL DIRECTOR Joseph William Foster Jarrettsville, Md.				25a. DATE REC'D. BY REGISTRAR MAR 31 1982		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

1000-1000 1000-1000 1000-1000 1000-1000

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 2 0 7 2 7 7

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Myrtle G. Annesley		2a. DATE OF DEATH MONTH DAY YEAR 3-13-82		2b. HOUR 9:10 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 31 1891	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Center		9. BALTIMORE CITY OR COUNTY OF DEATH Harford CO.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. CITY OR TOWN Balto. 13c. CITY OR TOWN Balto. 2124		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12c. KIND OF BUSINESS OR INDUSTRY	
14. FATHER'S NAME FIRST MIDDLE LAST Charles T. Dorgan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura V. Brooks		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
17. INFORMANT Harry R. Annesley, Shrewsbury, Pa.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 5500					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (the hospital) attended the deceased from 3/7 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.					
22b. SIGNATURE Andrew Nowakowski		DEGREE MD		22c. DATE SIGNED 3/13/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW NOWAKOWSKI MD		22e. ADDRESS 125 N. MAIN ST. BEL AIR MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-15-82		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGN MAR 15 1982 Francis J. [Signature]					

BP
DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Audley Albert Ashby						2a. DATE OF DEATH MONTH March DAY 21st YEAR 1982				2b. HOUR 12³⁷ MIN. PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 8 DAY 30 YEAR 1907		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.					
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Boatright		12b. KIND OF BUSINESS OR INDUSTRY Marina			
13a. STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Harford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2545 Old Robin Hood Rd			
14. FATHER'S NAME FIRST Stephen MIDDLE Glenn LAST Ashby						15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE A. LAST Freeland					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 223-03-0777		17. INFORMANT ADDRESS Rachel Scherry, 2545 Old Robin Hood Road, Havre de Grace, Md. 21078					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4920 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Emphysema (c) adenocarcinoma of prostate										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-21 , 19 82 , to 3-21 , 19 82 , that (I) (we) lost saw the deceased alive on 3-21 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Brian T. Yeo M.D. DEGREE M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/21/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brian T. Yeo - M.D.						22e. ADDRESS S. Union Ave. Havre de Grace, Md. 21078					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 23 Mar. 1981		23c. NAME OF CEMETERY OR CREMATORY Harford Mem. Gardens		23d. LOCATION CITY OR TOWN Aberdeen, R.D., Harford COUNTY Md. STATE 			
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399 ADDRESS 											

MAR 29 1982 BY REGISTRAR **James J. [Signature]**

1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037
2038
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
2061
2062
2063
2064
2065
2066
2067
2068
2069
2070
2071
2072
2073
2074
2075
2076
2077
2078
2079
2080
2081
2082
2083
2084
2085
2086
2087
2088
2089
2090
2091
2092
2093
2094
2095
2096
2097
2098
2099
2100

1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037
2038
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
2061
2062
2063
2064
2065
2066
2067
2068
2069
2070
2071
2072
2073
2074
2075
2076
2077
2078
2079
2080
2081
2082
2083
2084
2085
2086
2087
2088
2089
2090
2091
2092
2093
2094
2095
2096
2097
2098
2099
2100

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 2 7 9

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Lester Walter Barber Sr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>March 8, 1982</i>			2b. HOUR <i>12:35</i> AM	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>April 9, 1931</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>50</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VT</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD.	
10. CITY OR TOWN OF DEATH <i>Harford</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Mem Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Service Mgr.</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>Auto.</i>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Aberdeen</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Clyde Leroy Barber</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Edith Mabel McMahon</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>025-24-5797</i>	
17. INFORMANT <i>Mrs. Lucille Barber, Aberdeen, Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of the colon with</i> <i>1539</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Complicated metastases</i> (c) <i>Intestinal obstruction from tumor</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>3-1</i> , 19 <i>82</i> , to <i>3-8</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>3-8</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Uscante R. Conary</i>		DEGREE <i>Uscante R. Conary</i>		22c. DATE SIGNED <i>3/8/82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>V. CARAG JR</i>		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Mar. 11, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Carmel Metho. Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Emmorton Harford Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Howard K. McComas III, Abingdon, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 8 1982</i>		25b. REGISTRAR SIGNATURE <i>James Jean Nathan</i>	

March 2, 1952

Dear Mr. [illegible]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

Very truly yours,
[illegible signature]
MAR 8 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 2 8 0

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MILDRED MIDDLE BENSON LAST		MONTH 03 DAY 03 YEAR 82	
3 SEX Female		4. RACE Cau	
5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
MONTH 4 DAY 3 YEAR 11		71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
MD		USA	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Harford MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	
Fallston		Fallston General Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
HOUSE WIFE			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?	
13a. STATE MD 13b. COUNTY BALTO		13c. CITY OR TOWN Baltimore	
13d. STREET ADDRESS		13e. STREET ADDRESS	
7950 Bank St.			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME	
FIRST George MIDDLE KRAIG LAST		FIRST Rose MIDDLE BARNES LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
No		217 07 361	
17 INFORMANT		17 ADDRESS	
Dolores Szymanik		414 AIR MD 21014	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a)			
4100 DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b)			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
Dialo. Dehmen			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	
		HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED		21e. PLACE OF INJURY	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION		CITY OR TOWN	
STREET		COUNTY	
		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/3/82 to 3/3/82, that (I) (we) last saw the deceased alive on 3/3/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED	
V. J. NAIR M.D.		MAR 8 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
		1716 Fayad Road Jhark MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Removal		3/4/82	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
		CITY OR TOWN	
		COUNTY	
		STATE	
24. FUNERAL DIRECTOR		25a. DATE RECD. BY REGISTRAR	
NAME Anatomy Board		MAR 8 1982	
ADDRESS Balto., Md.		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

99

BP

Dynamic
Journal

100% COTTON



100% COTTON

100% COTTON

100% COTTON

100% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ELIZABETH MARIE BLAKELEY				2a. DATE OF DEATH MONTH DAY YEAR 3-19-82 2b. HOUR 10:32 AM			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11 15 1888		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH HAVERDE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVERDE GRACE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Smythe		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dunn		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 213-16-9302		17. INFORMANT ADDRESS Havre de Grace, Maryland 21078 Berlin J. Blakeley, Jr., 109 Darlington Road,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 5860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration pneumonia, CVA (c) Renal failure							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-17 , 19 82 , to 3-19 , 19 82 , that (I) (we) last saw the deceased alive on 3-19 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Brian T. Geo M.D. DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRIAN T. GEO M.D.				22e. ADDRESS S. Union Ave. Havre de Grace Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 22 Mar. 1982		23c. NAME OF CEMETERY OR CREMATORY Rock Run Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Havre de Grace Harford Md.	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399 ADDRESS				25a. DATE REC'D BY REGISTRAR MAR 24 1982 25b. REGISTRAR'S SIGNATURE Charles J. Nathan			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 2 8 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MAXWELL Boddy				2a. DATE OF DEATH MONTH DAY YEAR March 13 1982		2b. HOUR M 	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Mar. 29 1890		6. AGE (IN YEARS LAST BIRTHDAY) 91	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD	
10. CITY OR TOWN OF DEATH Harford de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer		12b. KIND OF BUSINESS OR INDUSTRY General	
13a. STATE MD		13b. COUNTY Cecil		13c. CITY OR TOWN Rising Sun		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Boddy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virgie Peak		16. STREET ADDRESS 120 Wilson Ave.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 246-14-0023		17. INFORMANT Gabrie Boddy same as deceased			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF A.S.C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) massive stroke for 2 days DUE TO, OR AS A CONSEQUENCE OF (c) Sudden onset							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Diabetes Mellitus							
19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 			
22a. I certify that (I) (this hospital) attended the deceased from 3-12 , 19 82 , to 3-13 , 19 82 , that (I) (we) last saw the deceased alive on 3-13 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edward C. Loo, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/15/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. LOO, M.D.		22e. ADDRESS Harford de Grace, Ind. 21078.					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 3-16-82		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE CONOWINGO Cecil MD	
24. FUNERAL HOME B. J. McMillan		25. DATE REC'D. BY REGISTRAR MAR 19 1982		26. REGISTRAR'S SIGNATURE Harold J. ...			

BP

11-2-80

19 221 15 1000

2/11

Hotel

4.2.1.

14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Zelphia JANE Bolen						2a. DATE OF DEATH MONTH DAY YEAR March 5 1982		2b. HOUR 4:00 P			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR JUNE 11 1899		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.V.A.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.					
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. STORE		12b. KIND OF BUSINESS OR INDUSTRY OWNER			
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE DE GRACE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1925 CHAPEL ROAD			
14. FATHER'S NAME FIRST MIDDLE LAST FREEBORN ASA HALL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SHIRLDA SARAH BALK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 233-50-2050A		17. INFORMANT ADDRESS CHOKIS B. BOLEN HAVRE DE GRACE, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Car door struck</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Auto coming in off highway</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Car door decompaction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21078	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>3-4</u> , 19 <u>82</u> , to <u>3-5</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>3-5</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE				3. DATE SIGNED <u>5/82</u>			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Anna Kawa M.D.</u>				22e. ADDRESS <u>319 So. Union Ave Harford MD 21078</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE MAR. 8, 1982		23c. NAME OF CEMETERY OR CREMATORY HARFORD MEM. GARDENS		23d. LOCATION CITY OR TOWN COUNTY STATE HARFORD MD					
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME P.A. HAVRE DE GRACE MD				25. DATE REC'D. BY REGISTRAR MAR 5 1982				26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

99

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 2 8 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bernice Joan Booker			2a. DATE OF DEATH MONTH DAY YEAR March 20 1982		2b. HOUR 10:50AM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 1 1921		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Harford	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD	13b. CITY OR TOWN Cecil	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS 219 Mt. Zion Road		
14. FATHER'S NAME FIRST MIDDLE LAST George B Jones	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie J Miller		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b. SOCIAL SECURITY NO. 214-22-9872		17. INFORMANT ADDRESS George Booker Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis - visceral & osseous DUE TO, OR AS A CONSEQUENCE OF (c) Breast carcinoma					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (CITY OR TOWN) COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/17/82 to 3/20/82 , that (I) (we) last saw the deceased alive on 3/17/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles J. Foley Jr. M.D.				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles J. Foley Jr. M.D.				22e. ADDRESS Harford, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-24-82	23c. NAME OF CEMETERY OR CREMATORY Beekley		23d. LOCATION (CITY OR TOWN) COUNTY STATE Darlington Harford Md.	
24. FUNERAL DIRECTOR NAME ARNOLD W. BEND		ADDRESS 353 Fountain St. Hdg, MD.		25a. DATE REC'D. BY REGISTRAR MAR 26 1982	
				25b. REGISTRAR'S SIGNATURE Charles J. Foley Jr.	

BP



Respectfully,
C. J. Folger

3/10/25

3/10/25

Charles J. Folger, M.D.
House of Grace, M.D.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 2 8 5

1- FOR
STATE
REGISTRAR

REG. NO.

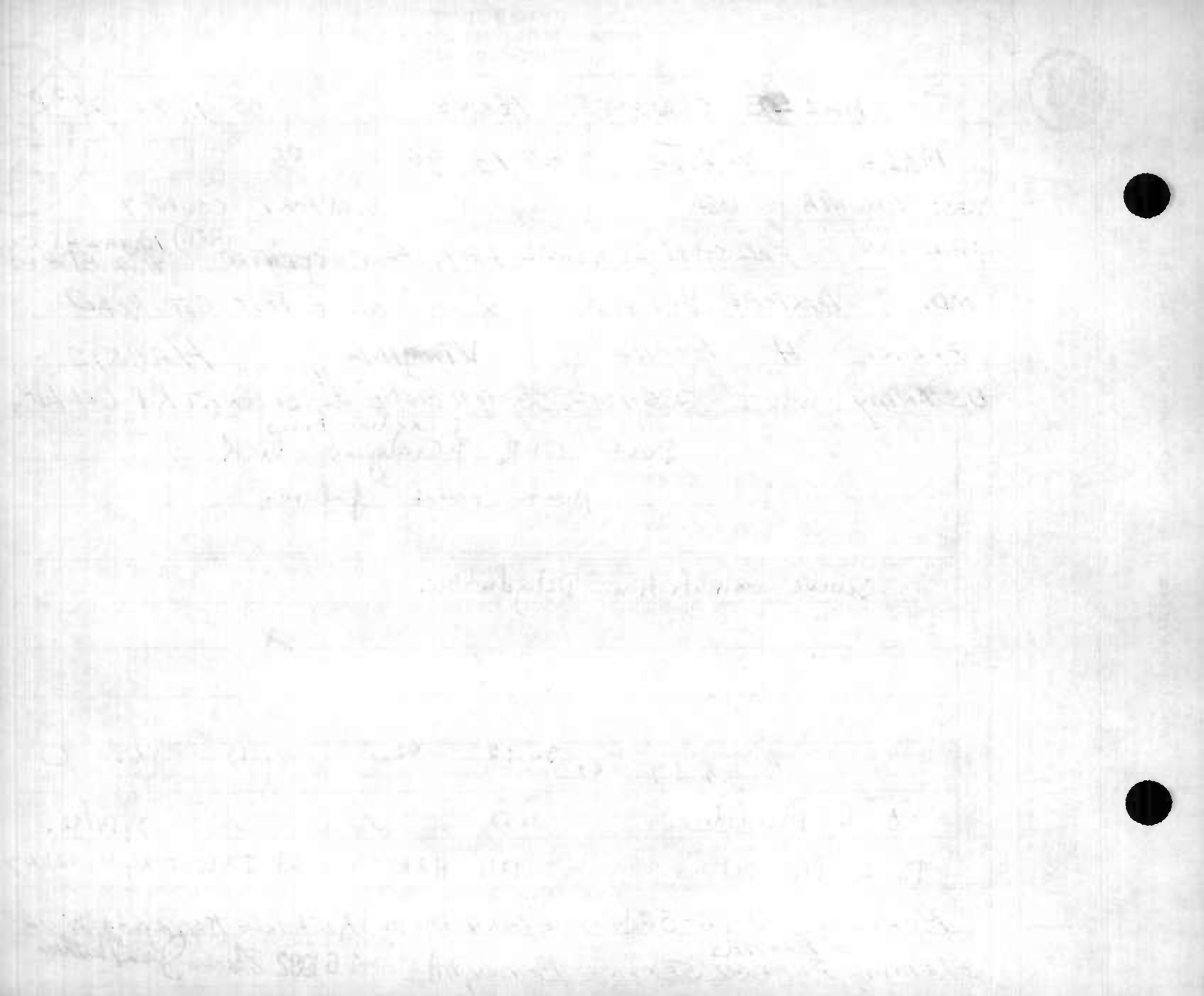
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HAZLE CLARENCE BOONE			2a. DATE OF DEATH MONTH DAY YEAR 03 13 82			2b. HOUR 2:12 P	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 09 13 96		6. AGE (IN YEARS LAST BIRTHDAY) 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b. KIND OF BUSINESS OR OCCUPATION W. VA. BJ & ED	
13a. STATE MD.		13b. COUNTY HARFORD		13c. CITY OR TOWN BEL AIR		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FRANCIS H BOONE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia HARRIS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) U.S. ARMY WWI			
16b. SOCIAL SECURITY NO. 235-105235		17. INFORMANT SON		17. ADDRESS 323 BELCREST RD BEL AIR			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post CPR DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrest 5849 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: Acute renal failure. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) Severe malnutrition - Dehydration.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3. 12. 19 82 to 3. 13. 19 82 , that (I) (we) last saw the deceased alive on 3. 13. 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. L. Pirovolidis		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/14/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. L. PIROVOLIDIS		22e. ADDRESS 1716 HARFORD Rd FALLSTON, Md. 21047					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-16-82		23c. NAME OF CEMETERY OR CREMATORY GRACE LAWN MEM.		23d. LOCATION CITY OR TOWN COUNTY STATE RUTHDALE HANAWHA W. VA.	
24. FUNERAL DIRECTOR NAME E BARNES		ADDRESS FLEMING FUNERAL SERVICE BENSON, Md		25a. DATE REC'D. BY REGISTRAR (S) REGISTRAR'S SIGNATURE 16 1982 Frances Jan Mathen			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 2 8 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elinore Clare Budzynski			2a. DATE OF DEATH MONTH DAY YEAR 03 25 82		2b. HOUR 8:35 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 03 29 1938		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10. CITY OR TOWN OF DEATH Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Homemaking
13a. STATE Maryland			13b. CITY OR TOWN Harford	13c. CITY OR TOWN Belair	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Devlin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Barrett		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-26-2139		17. INFORMANT ADDRESS Frank J. Budzynski 133 Regent Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4148 Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Old myocardial infarct - angina DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic - hypertensive coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 26 1982 , to March 26 1982 , that (I) (we) lost saw the deceased alive on March 26 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Rafael Perez-Mera		DEGREE M.D.		22c. DATE SIGNED 3-26-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rafael Perez-Mera, M.D.		22e. ADDRESS 5400 OLD COURT ROAD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/27/82	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Overlea Baltimore Md.	
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home		ADDRESS 7401 Belair Road		DATE REC'D. BY REGISTRAR MAR 29 1982	

4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) BONNIE S BURRIS						2a. DATE OF DEATH MONTH DAY YEAR MARCH 4, 1982		2b. HOUR 3:19 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR OCT. 14 1919		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 62			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.					
10. CITY OR TOWN OF DEATH HAURE de GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland						13b. COUNTY Harford		13c. CITY OR TOWN White Hall			
14. FATHER'S NAME FIRST MIDDLE LAST John Bedwell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah A. Miller		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2819 Troyer Road					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 170-24-1608		17. INFORMANT ADDRESS Margaret S. Hopkins, Street Md 21154							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Arterio Sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2: OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Congestive Heart Failure; Emphysema											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2-18 , 19 82 , to 3-4 , 19 82 , that (I) (we) last saw the deceased alive on 3-4 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Leticia J. Galuszko				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-7-82		23c. NAME OF CEMETERY OR CREMATORY Mt. Nebo		23d. LOCATION CITY OR TOWN COUNTY STATE Delta York Co. Pa.					
24. FUNERAL DIRECTOR NAME John H. Harkins				ADDRESS 600 Main St., Delta, Pa.		25a. DATE REC'D. BY REGISTRAR MAR 10 1982		25b. REGISTRAR'S SIGNATURE Anna J. [Signature]			

BP _____

1892
The following is a list of the
books in the collection of the
University of Michigan Library
which are now in the possession
of the University of Michigan
Library.

1. *History of the University of Michigan*
by John D. Beane
2. *History of the University of Michigan*
by John D. Beane

3. *History of the University of Michigan*
by John D. Beane
4. *History of the University of Michigan*
by John D. Beane

5. *History of the University of Michigan*
by John D. Beane
6. *History of the University of Michigan*
by John D. Beane

7. *History of the University of Michigan*
by John D. Beane
8. *History of the University of Michigan*
by John D. Beane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR
Clayton Eugene Cantwell					03 18 82					8:45 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
Male		White		07 10 1905		76		MONTHS DAYS HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Pennsylvania		USA				Harford County MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								
Forest Hill		1729 O'Connor Road 21050								
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					12b. KIND OF BUSINESS OR INDUSTRY		12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
13a. STATE					13b. CITY OR TOWN		13c. STREET ADDRESS			
Maryland					Baltimore		1811 Burnwood Road 21239			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
Frank Cantwell					Theresa Lynott					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No					204-09-7650		Patricia Loeffler 1729 O'Connor Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) ADENO CARCINOMA OF THE LUNG										
DUE TO, OR AS A CONSEQUENCE OF (b) WITH WIDESPREAD METASTASES										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):										
CORONARY ARTERY INSUFFICIENCY										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
			HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 19 72, to MARCH 19 82, that (I) (we) last saw the deceased alive on 3/5 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
Joseph D. Notarangelo					M.D.			3/19/1982		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
JOSEPH D. NOTARANGEL M.D.					301 ST. PAUL PLACE - BALTIMORE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial			3/22/82		St. John's Ch. Cem.		Long Green Baltimore Md.			
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
P.O. Box 147 Kingsville, Md. 21087					MAR 26 1982		E.F. Lassahn Funeral Home 11750 Belair Rd			

Page 10

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA-3, RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

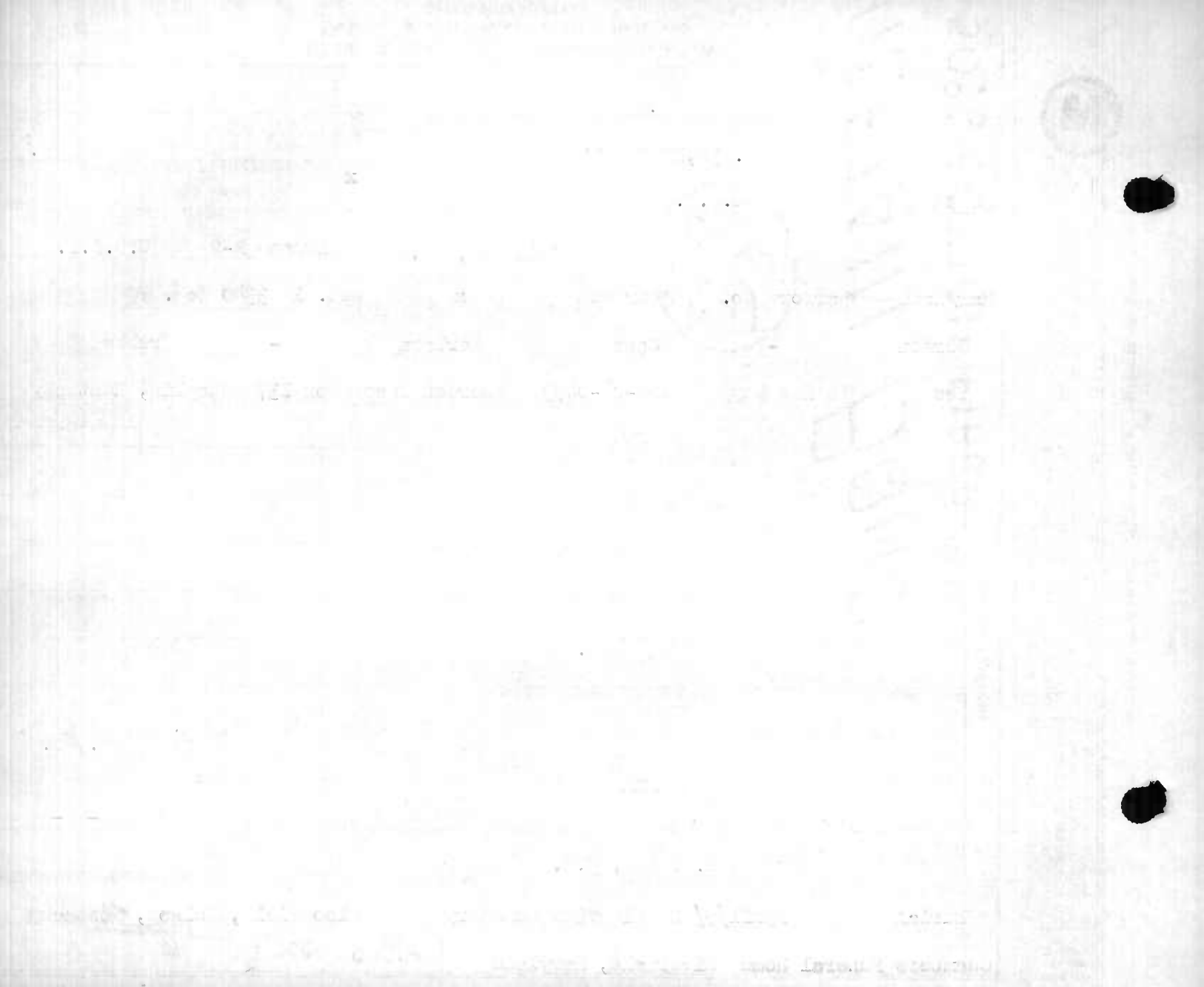
BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Jerry M. Case										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 29 1982				2b. HOUR M 11:30 A 30	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 30, 1959		6. AGE (IN YEARS) LAST BIRTHDAY 22 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 30 1982		7d. HOUR M 11:30 A 30			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD.			
10. CITY OR TOWN OF DEATH Abington				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bush River behind Jr's Bar, Rt. 40						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Airman E-2				12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Maryland		13b. COUNTY Harford Co.		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Det. 1 3340 Tch. TG							
14. FATHER'S NAME FIRST MIDDLE LAST Gerden - Case						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara - Grubbs									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes Active Duty						16b. SOCIAL SECURITY NO. 402-04-0459		17. INFORMANT ADDRESS Gerden Case Box 137 Chaplin, Kentucky							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ? DUE TO, OR AS A CONSEQUENCE OF (c) ?												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. HOUR A.M. MONTH DAY YEAR ? P.M. 3 29 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject found in water									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) water		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Bush River behind Jr's Bar, Rt. 40, Abington, Harford Co., Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Virginia L. Dolan						TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 3-31-82					
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.						ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE April/5/82		23c. NAME OF CEMETERY OR CREMATORY Highview Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Bloomfield, Nelson, Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Riverdale, Maryland						25a. DATE REC'D. BY REGISTRAR APR 6 1982				25b. REGISTRAR'S SIGNATURE [Signature]					



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

82 07290

1. FOR
STATE
REGISTRAR

REG. NO.

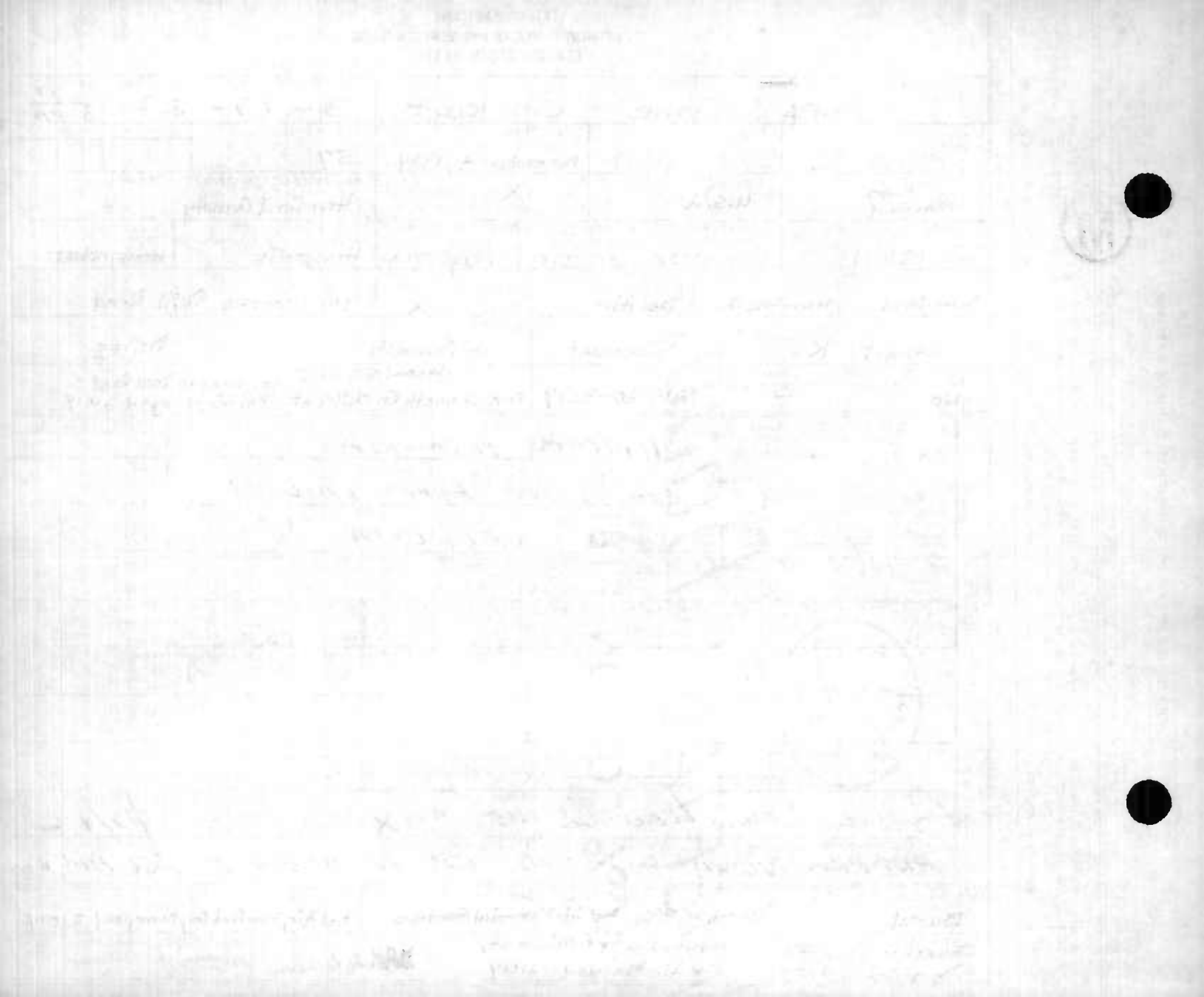
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna Jane Chilcoat			2a. DATE OF DEATH MONTH DAY YEAR 3-17-82		2b. HOUR 5:27 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR November 21, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10. CITY OR TOWN OF DEATH Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker
13a. STATE Maryland		13b. COUNTY Harford Co.	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Stuart K Richmond		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Miles			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-20-8397		17. INFORMANT (Name) ADDRESS (Husband) 838-6705 Mr. Kenneth G. Chilcoat 901 Moores Mill Road Bel Air, Maryland 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BILATERAL PNEUMONIA</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>SEVERE CACHEXIA</u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Andrew Nowakowski MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/17/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW NOWAKOWSKI MD		22e. ADDRESS 125 N. MAIN ST BEL AIR, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 20, 1982		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	
23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co., Maryland 21014		24. FUNERAL DIRECTOR Joseph William Foster W. Broadway & Williams St., Bel Air, Maryland 21014		25. DATE REC'D. BY REGISTRAR MAR 22 1982	
25b. REGISTRAR'S SIGNATURE Thane Garrison					

Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 2 9 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Wayman B. Christy				2a. DATE OF DEATH MONTH March DAY 9 YEAR 1982		2b. HOUR 5³⁰ P.M.	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH MAY DAY 7 YEAR 1915		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.	
10. CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Hartford Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ?		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. CITY OR TOWN Hartford		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13d. STREET ADDRESS 329 Ernest Lane					
14. FATHER'S NAME FIRST William MIDDLE B. LAST Christy		15. MOTHER'S MAIDEN NAME FIRST ? MIDDLE ? LAST ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217 16 8983		17. INFORMANT ADDRESS Bertha Buel 107 Morris Ave Penns 08069			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cardiomyopathy 2% Ethanolism DUE TO, OR AS A CONSEQUENCE OF (c) 4255 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-9 , 19 82 , to 3-9 , 19 82 , that (I) (we) last saw the deceased alive on 3-9 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (all) (did not) view the body after death.							
22b. SIGNATURE Brian T. Yoo M.D. DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 3-9-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brian T. Yoo M.D.				22e. ADDRESS Union Ave, Harre de Grace Md. 21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 3/13/82		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board ADDRESS Balto., Md.				25a. DATE REC'D. BY REGISTRAR MAR 18 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]	

Handwritten text, mostly illegible due to fading and bleed-through. The text appears to be organized into sections, possibly by date or topic, with some lines clearly visible such as "The following is a list of..." and "The first of these is...".

CERTIFICATE OF DEATH

REG. NO.

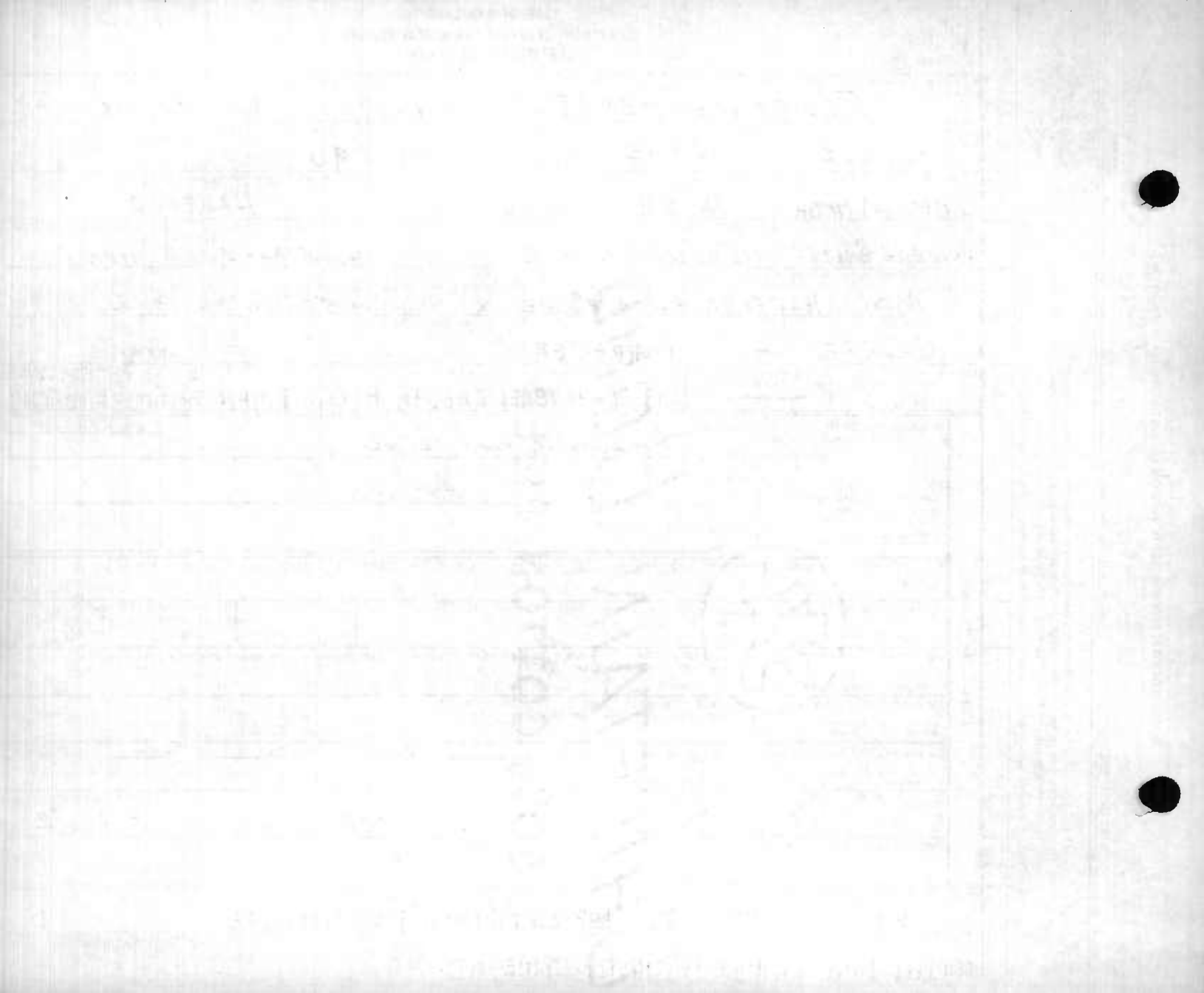
1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FLORENCE HECHT COBURN			2a. DATE OF DEATH MONTH DAY YEAR MAR. 30, 1982			2b. HOUR 10³⁰ P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 28, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 90		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ONTARIO CANADA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10. CITY OR TOWN OF DEATH HARFORD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1155. UNION. AVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MD.		13b. COUNTY HARFORD		13c. CITY OR TOWN HARFORD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1155. UNION. AVE.	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE - FORRESTER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 213-46-4673		17. INFORMANT ADDRESS 6033 BERKELEY AVE ELIZABETH H. GOODMAN BALTIMORE MD 21209			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Constrictive Heart Failure 4279 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Acute Cardiac Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1981 , to 3.30 , 19 82 , that (I) (we) last saw the deceased alive 3:15 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/31. 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE APR. 1, 1982		23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.		
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA.			ADDRESS HARFORD, MD.			25a. DATE REC'D. BY REGISTRAR APR 5 1982		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.				3 2 0 7 2 9 3			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>HELEN Ruth CRESWELL</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>3 29 82</i>		2b. HOUR <i>12 A.M.</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Dec. 18, 1917</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD</i> MD.			
10. CITY OR TOWN OF DEATH <i>FALLSTON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>FALLSTON GEN HOSP</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Site Manager</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Citizens Center</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Street</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>3438 Conowingo Rd.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles W. Jones</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Matilda Bagley</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>R16-18-7915</i>		17. INFORMANT ADDRESS <i>Elle M. Stamper, Street, Md. 21154</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> <i>4275</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Chronic obstructive pulmonary disease</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>Cardiac arrhythmia</i>									APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AS WOUND <input type="checkbox"/> AT WOUND <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>NOV 19 80</i> to <i>MAR 10 82</i> , that (I) (we) last saw the deceased alive on <i>MAR 10 82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Brian T. Yeo M.D.</i>		22c. DATE SIGNED <i>3/29/82</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Brian T. Yeo M.D.</i>					
22e. ADDRESS <i>801 S. Union Ave</i>		22f. DATE REC'D. BY REGISTRAR <i>APR 1 1982</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3-31-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Darlington</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Darlington Harford Co. Md.</i>			
24. FUNERAL DIRECTOR NAME <i>John H. Harkins</i>		ADDRESS <i>600 Main St., Delta, PA</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 1 1982</i>		25b. REGISTRAR'S SIGNATURE <i>Harve DeGree</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1- FOR STATE REGISTRAR			1 DECEASED NAME FIRST MIDDLE LAST <i>Iva Earle Crowther</i>		7a DATE OF DEATH MONTH DAY YEAR <i>3/16/82</i>	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>8/20/1897</i>		7b HOUR <i>9¹⁰ AM</i>
7c BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>		7d CITIZEN OF WHAT COUNTRY? <i>USA</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
10 CITY OR TOWN OF DEATH <i>FALLSTON</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>FALLSTON GENERAL HOSPITAL</i>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Harford MD</i>		17b KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>
13a STATE <i>MD</i>			13b COUNTY <i>HARFORD</i>		13c CITY OR TOWN <i>FOREST HILL</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Issac Daniel Amos</i>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bertha Julia Thompson</i>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b SOCIAL SECURITY NO. <i>705-10-8823</i>		17 INFORMANT ADDRESS <i>Earle W. Crowther Forest Hill, Md.</i>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Constrictive Heart Failure</i> 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Related pneumonia</i> (c) <i>Chronic Obstructive Lung Disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (1) (the hospital) attended the deceased from <i>2/23</i> 19 <i>82</i> to <i>3/16</i> 19 <i>82</i> , that (1) (the) lost saw the deceased alive on <i>3/15</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (do) (did not) view the body after death.						
22b SIGNATURE <i>Andrzej Nowakowski MD</i>				DEGREE <i>MD</i>		22c DATE SIGNED <i>3/16/82</i>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Andrzej Nowakowski MD</i>				22e ADDRESS <i>125 N. Main St. Bel Air, MD</i>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>3/19/1982</i>		23c NAME OF CEMETERY OR CREMATORY <i>Nazarene Cemetery Hickory, Harford, Md.</i>		23d LOCATION CITY OR TOWN COUNTY STATE
74 FUNERAL DIRECTOR NAME ADDRESS <i>M. Gladden Kurtz Jarrettsville, Md.</i>						

MAR 15 1982

0242

22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 82 07295			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY R. CUMMINGS				2b. HOUR 5:25 PM			
3. SEX F		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR July 10, 1916		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 65	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Machinery	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Maryland Harford Street				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST John F. Redding				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Rigdon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 220-34-6849			
17. INFORMANT ADDRESS Andrew T. Cummings, Street, Maryland				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (c) E.H.D. 3989			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/14 , 19 82 , to 3/14 , 19 82 , that (I) (we) last saw the deceased alive on 2/14 , 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph Reinhardt				DEGREE M.D.		22c. DATE SIGNED Mar. 14, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Reinhardt				22e. ADDRESS Rock Spring Road, Bel Air, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 17, 1982		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gdns		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Maryland	
24. FUNERAL DIRECTOR NAME John H. Harkins, 600 Main St., Delta, PA				25. DATE REC'D BY REGISTRAR MAR 18 1982			

BP

1. *[Faint, illegible handwritten text]*

2. *[Faint, illegible handwritten text]*

3. *[Faint, illegible handwritten text]*

4. *[Faint, illegible handwritten text]*

5. *[Faint, illegible handwritten text]*

6. *[Faint, illegible handwritten text]*

7. *[Faint, illegible handwritten text]*

8. *[Faint, illegible handwritten text]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENICIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 7 2 9 6	
1. DECEASED NAME (TYPE OR PRINT) Joseph D'Anna, Jr.						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 3 27 19 82		2b. HOUR M			
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 7 25 39	6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD 3 27 19 82		7d. HOUR 6:PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10. CITY OR TOWN OF DEATH Jarrettsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rock State Park				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer Assoc.		12b. KIND OF BUSINESS OR INDUSTRY State Rds. Com.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STREET ADDRESS 320 Marydell Road 21229					
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST Joseph D'Anna Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret E. Horwath							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219-38-9957		17. INFORMANT ADDRESS Mrs. A. Bernadine D'Anna Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8849 IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR 3:35 PM MONTH DAY YEAR 3/27 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) high fall/slipped on rock							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Park		21f. LOCATION STREET CITY OR TOWN COUNTY STATE RockState Park, Jarrettsville, HarfordCo, MD							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE H. R. Guard				TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER				DATE SIGNED 3/29/82			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard MD				ADDRESS 111 Penn Street, Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/1/82		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Witzke P.A. ADDRESS 1630 Edmondson Avenue, Catonsville, Md. 21228				25a. DATE REC'D. BY REGISTRAR MAR 30 1982		25b. REGISTRAR'S SIGNATURE James J. ...					

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

0800-1-47

38

Baltimore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

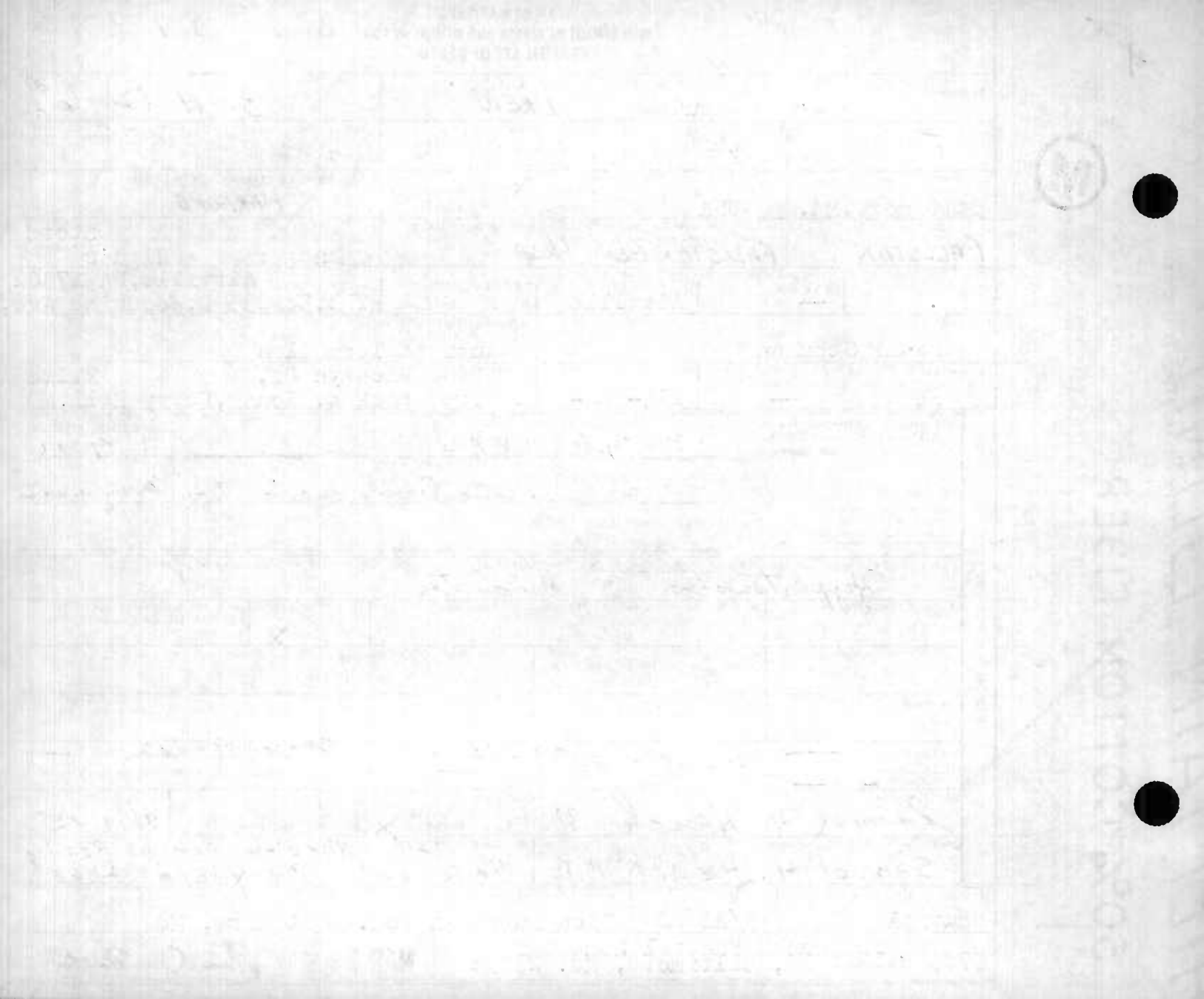
FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 2 9 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Cecelia Augusta DREW			2a. DATE OF DEATH MONTH 3 - DAY 19 - YEAR 82			2b. HOUR 6 AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 3 / DAY 10 / YEAR 07		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.					
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY High's Store			
13a. STATE PA.		13b. COUNTY ---		13c. CITY OR TOWN Airville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Airville, PA 17302 RT 2, Box 235 D, Woodbine Ave,			
14. FATHER'S NAME FIRST Frank MIDDLE Schuman LAST Schuman				15. MOTHER'S MAIDEN NAME FIRST Augusta MIDDLE Tormollen LAST Tormollen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMATION 2902 Richlyn Dr, 21128 214-22-8020-A Frederick W. Young, Perry Hall, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple CVA's 4380 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Cerebrovascular Dis. (c) Many years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension & Diabetes											
19a. DATE OF OPERATION 2/9/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET White Ford		CITY OR TOWN White Ford		COUNTY Maryland		STATE 21160	
22a. I certify that (I) (this hospital) attended the deceased from Jan. 1981 , 19 1982 , to March 19 , 19 82 , that (I) was last saw the deceased alive on March 17 , 19 82 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.											
22b. SIGNATURE Samuel H. Henck, M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel H. Henck, M.D.						22e. ADDRESS 721 Wheeler School Road White Ford, Maryland 21160					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/22/82		23c. NAME OF CEMETERY OR CREMATORY Zion Lutheran Cem.		23d. LOCATION CITY OR TOWN Baltimore, Md		COUNTY Md		STATE Md	
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home 9705 Belair Rd, Baltimore, Md. 21236						25a. DATE REC'D. BY REGISTRAR MAR 22 1982		25b. REGISTRAR'S SIGNATURE Thome Jan			

BP



Item 18b G566 4/6/82 dad

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 2 9 8

FOR
1- STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LIDA ELLEN FAMOUS			2a DATE OF DEATH MONTH DAY YEAR 3-14-82			2b HOUR M ---			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 8 22 01		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. ---	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10 CITY OR TOWN OF DEATH ABINGDON, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3108 Philadelphia Road				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY ---	
13a STATE MD			13b CITY OR TOWN HARFORD		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 3108 PHILADELPHIA RD		
14 FATHER'S NAME FIRST MIDDLE LAST Howard --- Coe			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora --- (unknown)						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO. 215-82-6242		17 INFORMANT ADDRESS Mrs. Marlene Coughlan, 9238 Osprey Ct. Columbia Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (1) and (2). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4360 DUE TO, OR AS A CONSEQUENCE OF, Arxymia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) --- ARRYTHMIA --- DUE TO, OR AS A CONSEQUENCE OF, ARTERIOSCLEROSIS (c) ---								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) STROKE									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dante N. Monakul					DEGREE ---		22c. DATE SIGNED 3/15/82		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE N. MONAKUL					22f. ADDRESS 1401 E. CAROL AVE 21078				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 17, 1982		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air, Harford		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md		
24 FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.					25a. DATE REC'D. BY REGISTRAR (TYPE OR PRINT) MAR 16 1982				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) GLADYS DRYDEN FORD			2a. DATE OF DEATH MONTH 3 DAY 23 YEAR 82		2b. HOUR 6:58 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH Oct. DAY 6 YEAR 1906		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.		10. CITY OR TOWN OF DEATH FALLSTON			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bank employee					
12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Fallston	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 416 Record Rd.			
14. FATHER'S NAME FIRST Paul MIDDLE H. LAST Dryden			15. MOTHER'S MAIDEN NAME FIRST Ola MIDDLE Marriner LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-22-7650		17. INFORMANT Francis Ford	
17. ADDRESS Md.		416 Record Rd., Fallston			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Vertical Fibrotosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Medal		21f. LOCATION STREET CITY OR TOWN COUNTY STATE March 82	
22a. I certify that (I) (the hospital) attended the deceased from 3/22/82 to March 82 , that (I) (we) lost saw the deceased alive on 3/22/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (dis) (did not) view the body after death.					
22b. SIGNATURE R Smith		DEGREE		22c. DATE SIGNED 3/22/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R Smith		22e. ADDRESS Fallston Gen Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/25/82		23c. NAME OF CEMETERY OR CREMATORY Beechwood	
23d. LOCATION CITY OR TOWN COUNTY STATE Princess Anne, Somerset, Md.					
24. FUNERAL DIRECTOR NAME James H. Williams ADDRESS Princess Anne, Md.		25. DATE REC'D. BY REGISTRAR MAR 29 1982		25. REGISTRAR'S SIGNATURE Francis Ford	

Female	White	Oct. 6, 1905	25
Male	W.S.	x	
Paul	M.	Wyden	Old
Ma.	Harford	Religion	Old Record Rd.
no			Bank employee

213-22-7050 Francis Ford, Old Record Rd., Religion

[Faint, illegible handwritten notes and stamps are visible in this section.]

Princeton Anne Somerset, Md.

Princeton Anne, Md.

Princeton Anne Somerset, Md.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT - AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRES. STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Jean		FIRST NMN		MIDDLE FRUS		LAST feri		2a. DATE KNOWN OF DEATH		MONTH <input type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input type="checkbox"/>		2b. HOUR <input type="checkbox"/>			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH 1 DAY 24 YEAR 17		6. AGE (IN YEARS) LAST BIRTHDAY 65 YRS.		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD MONTH 3 DAY 6 YEAR 82		2d. HOUR 7:12 M. 2	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.J.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD			
10. CITY OR TOWN OF DEATH HARFORD				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired				12b. KIND OF BUSINESS OR INDUSTRY HOME MILK			
13a. STATE N.J.				13b. COUNTY ESSEX				13c. CITY OR TOWN Belleville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS 61 SALTER PLACE.				14. FATHER'S NAME FIRST JOSEPH MIDDLE - LAST GAMMARO				15. MOTHER'S MAIDEN NAME FIRST FLORENCE MIDDLE - LAST CORDASCO							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 135-67-8846				17. INFORMANT NICHOLAS FRUSTERI				ADDRESS SAME			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) CORONARY Heart Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) ASCVD (c) ASCVD												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Luis E. Renjel				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 3-6-82			
EXAMINER'S NAME (TYPE OR PRINT) LUIS E. RENJEL				ADDRESS 464											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 3-9-82				23c. NAME OF CEMETERY OR CREMATORY GLENDAL CEM.				23d. LOCATION CITY OR TOWN BELTONFIELD COUNTY ESSEX STATE N.J.			
24. FUNERAL DIRECTOR NAME MITCHELL E. H.P.A. HAVREDE GRACE MD. ADDRESS				25a. DATE REC'D. BY REGISTRAR MAR 9 1982				25b. REGISTRAR'S SIGNATURE [Signature]							

GRAMMAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8207301	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Georgia Kate Garnatt</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>3 30 82</i>		2b. HOUR <i>3</i> M			
3. SEX <i>Female</i>		4. RACE <i>CAUCASIAN</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 22 07</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford County</i> MD.					
10. CITY OR TOWN OF DEATH <i>Fallston</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fallston General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Homemaking</i>			
13a. STATE <i>Maryland</i>						13b. CITY OR TOWN <i>Edgewood</i>		13c. STREET ADDRESS <i>3001 Pulaski Hwy. 21040</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charlie Hockaday</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Almeda Flippo</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>250-58-9627</i>		17. INFORMANT ADDRESS <i>Edith M. Sullivan 3001 Pulaski Hwy.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> <i>4292</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASCVD</i> (c) <i>ASCVD</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>3/15 81 to 3/30 82</i>							
22a. I certify that (I) (this hospital) attended the deceased from <i>3/15 81</i> to <i>3/30 82</i> that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) <i>1982</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE <i>[Signature]</i>						DEGREE		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R Smith</i>						22e. ADDRESS <i>Fallston Gen Hospital</i>		22f. DATE REC'D. BY REGISTRAR			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4/2/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Overlea Baltimore Md.</i>		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME <i>LESSON F. H.</i>						24b. ADDRESS <i>7901 BELAIR</i>		24c. DATE REC'D. BY REGISTRAR <i>APR 6 1982</i>			
24d. REGISTRAR'S SIGNATURE <i>[Signature]</i>						24e. REGISTRAR'S SIGNATURE <i>[Signature]</i>		24f. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP

1950-1951

2

AD

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 3 0 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Edith R GIANCONTIERE				2a. DATE OF DEATH MONTH DAY YEAR 3 24 82			
3. SEX Female		4. RACE W White		5. DATE OF BIRTH MONTH DAY YEAR 1 6 18		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD County MD.	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clothing		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13e. STREET ADDRESS 2510 Thornberry Drive	
14. FATHER'S NAME FIRST MIDDLE LAST William Rilee				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Merideth Stubfield			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-22-4979		17. INFORMANT ADDRESS John A. Giancontiere 2510 Thornberry Dr. Edgewood, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Gram Negative Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Right Upper Lobe Pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH About 1 week							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Lymphatic Leukemia, Chronic Adrenal Insufficiency							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR not applicable		21c. NATURE OF INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.							
22b. SIGNATURE M. M. Gatz				DEGREE MD		22c. DATE SIGNED 2/24/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAZARON, MANUEL				22e. ADDRESS 1131 Bel Air Rd Bel Air, Md 21014			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE March 27, 1982		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 26 1982		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Lloyd L. Gibson					2a. DATE OF DEATH MONTH DAY YEAR 3- 4 82 2b. HOUR 7 P M				
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Oct. 9, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD			
10. CITY OR TOWN OF DEATH HAYREDE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home				12a. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE) RET. WEAVER		12b. KIND OF BUSINESS OR INDUSTRY RETIRED	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE MD		13b COUNTY Harford		13c CITY OR TOWN HAYREDE GRACE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 631 ONTARIO ST.	
14 FATHER'S NAME FIRST MIDDLE LAST HUGH BOYD GIBSON					15. MOTHER'S MAIDEN NAME FIRST MIDDLE SARAH - MATTHUEN				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 165-10-5831		17 INFORMANT ADDRESS MRS. MARGARET WILSON - SAME		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Concise Arrost</u> 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Antenatal</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Antenatal</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>3/7/82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dante Monakel</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/8/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKEL					22e. ADDRESS 6725 Union Ave Home de Care Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-7-82		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE HAYREDE GRACE, HARFORD MD.			
24. FUNERAL DIRECTOR NAME MITCHELL F.H.P.A. HAYREDE GRACE, MD.					25a. DATE REC'D. BY REGISTRAR MAR 8 1982		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

RECEIVED
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.



1914
No. 1
The following is a list of the
names of the persons who have
been appointed to the
positions of
agents in the
various districts
of the
Department of
Agriculture
for the year
1914.

U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.



1914
No. 1
The following is a list of the
names of the persons who have
been appointed to the
positions of
agents in the
various districts
of the
Department of
Agriculture
for the year
1914.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 0 7 3 0 4	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		
FIRST MIDDLE LAST Frances Shepherd Haggerty			MONTH DAY YEAR March 28 1982		2b. HOUR 6:45 P ^M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 11, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Int. Design
13a. STATE New York		13b. COUNTY Orange	13c. CITY OR TOWN Port Jervis	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robinson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Brodhead			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 073-26-1708		17. INFORMANT ADDRESS Blanche D. Webb Pylesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S.C.D. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks > 3 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Pneumonitis - bilateral - 3 weeks					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT IF MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3 - 7, 19 82, to 3 - 28, 19 82, that (I) (we) last saw the deceased alive on 3 - 28, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward C. Loo, M.D.		DEGREE M.D.		22c. DATE SIGNED 3/28/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward C. Loo, M.D.		22e. ADDRESS Havre de Grace, Ind. 21078.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/31/1982		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Hackettstown, New Jersey					
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz		ADDRESS Jarrettsville, Md.		25a. DATE REC'D. BY REGISTRAR MAR 30 1982	
		25b. REGISTRAR'S SIGNATURE Frances Jan Nathan			

27

9-11-80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										8 2 0 7 3 0 5	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>ELIZABETH B. HAMILTON</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>MARCH 4 1982</u>		2b. HOUR <u>9⁵⁰ A.M.</u>				
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>JUNE 3, 1893</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>88</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pa.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>HARFORD</u> MD.					
10. CITY OR TOWN OF DEATH <u>HAVRE DE GRACE</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HARFORD MEMORIAL HOSPITAL</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY ---			
13a. STATE <u>md</u>		13b. COUNTY <u>Harford</u>		13c. CITY OR TOWN <u>Havre de Grace</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>104 Wilson Street</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Joseph Carson</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE <u>Margaret Bell</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>			16b. SOCIAL SECURITY NO. <u>157-28-9805</u>		17. INFORMANT ADDRESS <u>Elizabeth Carson, Havre de Grace, Maryland.</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular Hemorrhage</u> 4310 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive cerebro-vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diabetes Mellitus</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 16</u> , 19 <u>82</u> , to <u>MARCH 4</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>MARCH 4</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Irvin L. Waxman</u>					DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/4/82</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>IRVIN L. WAXMAN</u>					22e. ADDRESS <u>So. Union Ave Havre de Grace, Md</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>			23b. DATE <u>Mar. 5, 1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Capellay Courthouse, Capellay, N. J.</u>				
24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son, Perryville, Maryland</u>					25a. DATE REC'D. BY REGISTRAR <u>MAR 8 1982</u>		25b. REGISTRAR <u>James J. [Signature]</u>				

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP _____

DHMH - 16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) MIL DRED E. HARKNESS					2a. DATE OF DEATH MONTH DAY YEAR HOUR MARCH 4, 1982 3:31 AM				
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 23, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MD.		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE DE GRACE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 124 BAY BLVD.	
14. FATHER'S NAME FIRST MIDDLE LAST LAURENCE - NICHOLS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY E. WHITE HEAD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-12-4993		17. INFORMANT ADDRESS RUSSELL S. HARKNESS - SAME					
18. CAUSE OF DEATH (Enter only one cause per line, or as many as needed) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2-10 , 19 82 , to 3-4 , 19 82 , that (I) (we) lost saw the deceased alive on 3-4 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Leticia S. Galvez M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LETICIA S. GALVEZ				22e. ADDRESS HAVRE DE GRACE, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-6-82		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE HAVRE DE GRACE, HARFORD, MD.			
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME HAVRE DE GRACE MD				25a. DATE REC'D. BY REGISTRAR MAR 6 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



1. The first part of the report is a summary of the work done during the year. It includes a list of the projects and a brief description of the work done on each. The second part of the report is a detailed account of the work done on each project. It includes a description of the methods used, the results obtained, and a discussion of the significance of the work. The third part of the report is a list of the publications and reports produced during the year. It includes a list of the titles, authors, and dates of the publications and reports. The fourth part of the report is a list of the names of the persons who have contributed to the work during the year. It includes a list of the names, titles, and institutions of the persons who have contributed to the work during the year.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John MAURICE Harlan			2a. DATE OF DEATH MONTH DAY YEAR 3-19-82			2b. HOUR 9⁵⁰ M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 16 99		6. AGE (IN YEARS LAST BIRTHDAY) (82) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Agriculture	
13a. STATE Maryland			13b. COUNTY Harford Co.		13c. CITY OR TOWN Fallston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Amoss Harlan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Watson			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 217-36-3642			17. INFORMANT (NAME) (RELATIONSHIP) Wife 877-7721			ADDRESS 2840 PLEASANTVILLE ROAD FALLSTON, MARYLAND 21047			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery 4149 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe CAD DUE TO, OR AS A CONSEQUENCE OF (c) - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Renal Failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 3/19/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Harlan		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 19 March 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V-S- Nair				22e. ADDRESS 1716 Hanford Road, Fallston - MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 22, 1982		23c. NAME OF CEMETERY OR CREMATORY LITTLE FALLS FRIENDS Cem,		23d. LOCATION CITY OR TOWN COUNTY STATE Fallston, Harford Co Maryland 21047			
24. FUNERAL DIRECTOR Joseph William Foster W. Broadway & Williams St Baltimore, Maryland 21014				25a. DATE REC'D. BY REGISTRAR MAR 23 1982		25b. REGISTRAR'S SIGNATURE James J. Nathan			

STATE OF NEW YORK
IN SENATE
January 1, 1902

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
JANUARY 1, 1902

ALBANY:
J.B. LIPPINCOTT & CO. PRINTERS
1902

WILLIAM A. HARRIS, COMMISSIONER
OF THE LAND OFFICE

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS
1902

THE LAND OFFICE
OF THE STATE OF NEW YORK
HAS THE HONOR TO ACKNOWLEDGE
THE RECEIPT OF THE
REPORT OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
JANUARY 1, 1902

WILLIAM A. HARRIS, COMMISSIONER
OF THE LAND OFFICE

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS
1902

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

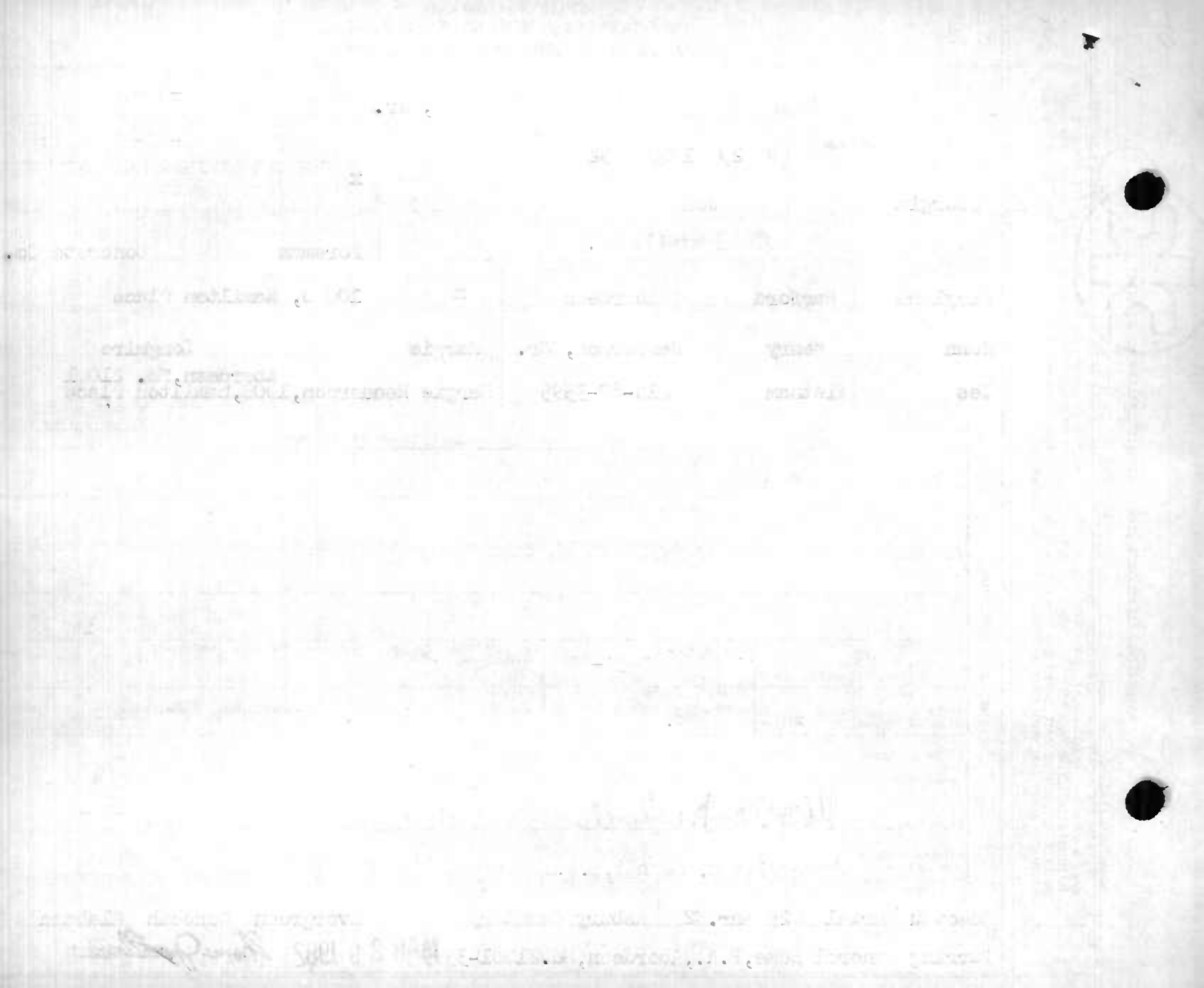
DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOHN HENRY HENDERSON, Jr.			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 3 DAY 21 YEAR 82			2b. HOUR 8:05A		
3. SEX male	4. RACE black	5. DATE OF BIRTH MONTH 9 DAY 29 YEAR 1949	6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0	IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD 3-21-82		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County		
10. CITY OR TOWN OF DEATH Perryman		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 206 Spetulia Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Concrete Co.
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST John MIDDLE Henry LAST Henderson, Sr.		15. MOTHER'S MAIDEN NAME FIRST Margie MIDDLE Longmire LAST Longmire		13e. STREET ADDRESS 100 B, Hamilton Place				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) Vietnam		16b. SOCIAL SECURITY NO. 418-60-3595		17. INFORMANT Margie Henderson ADDRESS Aberdeen, Md. 21001 100B, Hamilton Place		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) Gunshot wound to chest and abdomen DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY 1:30AM 3-21-82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) bldg.		21f. LOCATION 206 Spetulia Rd. Perryman, Maryland				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE Margie One Knell		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER			DATE SIGNED 3-21-82	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial		23b. DATE 25 Mar. 82		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery			23d. LOCATION CITY OR TOWN Evergreen COUNTY Conecuh STATE Alabama	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., ADDRESS Aberdeen, Md. 21001-3399		25. DATE REC'D. BY REGISTRAR MAR 29 1982		26. REGISTRAR'S SIGNATURE Thane J. [Signature]				

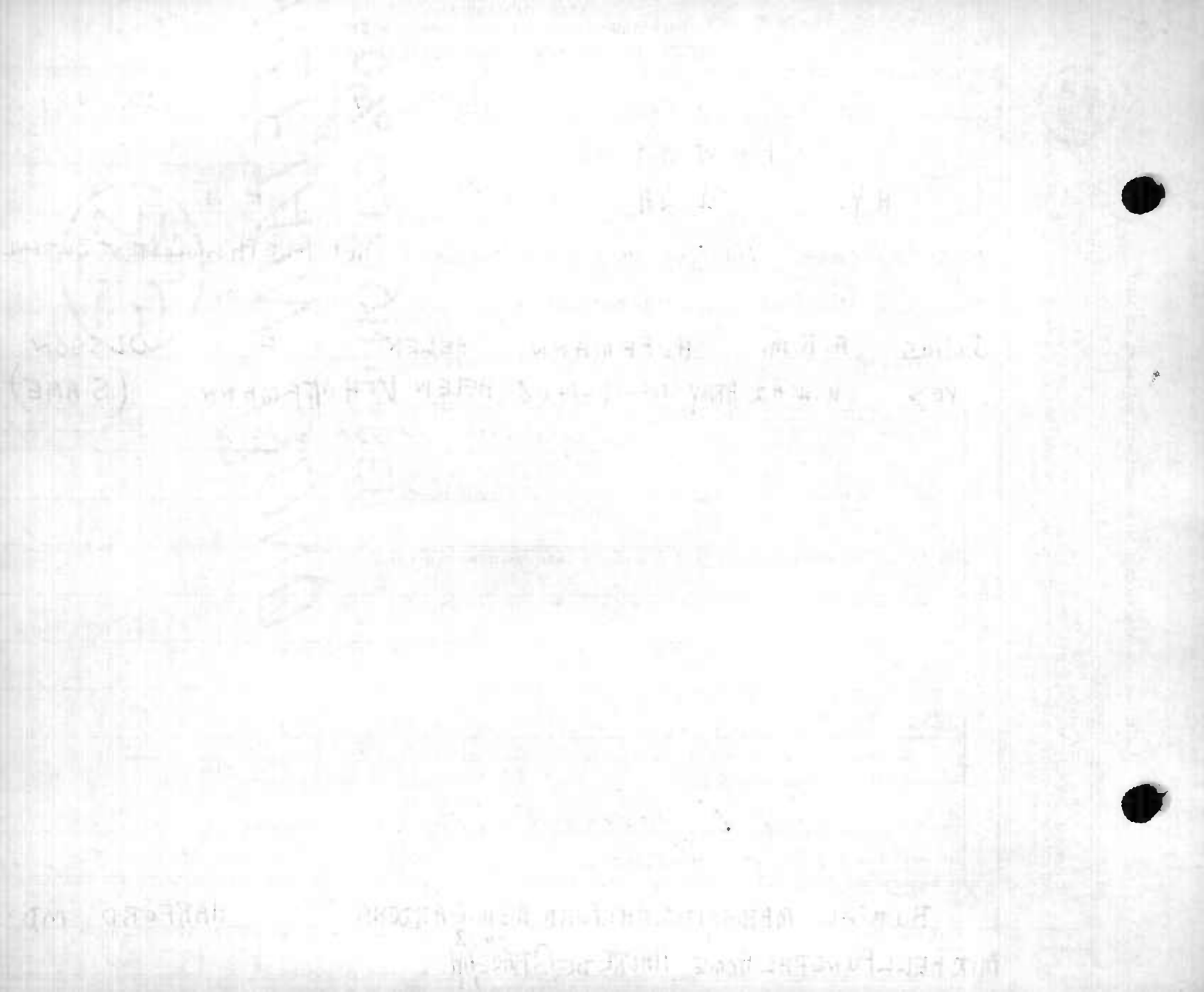


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 7 3 0 9	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Julius ALFred Hoffmann										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 3 26 19 82	
3. SEX M		4. RACE W		5. DATE OF BIRTH (MONTH DAY YEAR) FEB 27 1924		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YR. MONTHS DAYS		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 26 19 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH HAUREDE GRACE				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. TELEPHONE CO.		12b. KIND OF BUSINESS OR INDUSTRY TEST BUREAU	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE md		13b. COUNTY Harford		13c. CITY OR TOWN HAUREDE GRACE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6 Hopewell Rd			
14. FATHER'S NAME FIRST MIDDLE LAST Julius A. R. M. Hoffmann										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN A. OLSSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. W.W.#2 ARMY 104-16-1408		17. INFORMANT HELEN V. HOFFMANN				ADDRESS (SAME)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) CORONARY Heart Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASUDD DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Luis E Rempel						TITLE (SPECIFY) Deputy		DATE SIGNED 3-26-82			
EXAMINER'S NAME (TYPE OR PRINT) LUIS E REMPL						ADDRESS 464 Alliance St. Harford					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE MAR-30-1982		23c. NAME OF CEMETERY OR CREMATORY HARFORD MEM. GARDENS		23d. LOCATION CITY OR TOWN COUNTY STATE HARFORD MD.			
24. FUNERAL DIRECTOR NAME MICHAEL FUNERAL HOME						ADDRESS 21078		25a. DATE REC'D. BY REGISTRAR MAR 30 1982			
						25b. REGISTRAR'S SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) BABY BOY HOLLIS					2a. DATE OF DEATH MONTH DAY YEAR 2 28 82 2b. HOUR 10 ⁴⁵ P ^M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 28 82		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 1 53		IF UNDER 1 YEAR IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10. CITY OR TOWN OF DEATH HAURE de GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY HARFORD		13c. CITY OR TOWN H de G		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 844 Locust Rd (Parents)	
14. FATHER'S NAME FIRST MIDDLE LAST Donald Lee Beavers Jr					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROBIN Elizabeth DURHAM				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Extreme Immature Baby DUE TO, OR AS A CONSEQUENCE OF (c) 7798									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/28 19 82 to 2/28 19 82 , that (I) (we) last saw the deceased alive on 2/28 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Phillip P. Yim DEGREE Attending Physician					22c. DATE SIGNED 2/28				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Phillip P. Yim					22e. ADDRESS 504 So. Union Ave. HAURE de GRACE Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation		23b. DATE 3-17-82		23c. NAME OF CEMETERY OR CREMATORY Harford Mem. Hospital		23d. LOCATION CITY OR TOWN COUNTY STATE HAURE de GRACE Harford MD			
24. FUNERAL DIRECTOR Donald S. Canfield Jr					24a. DATE REC'D. BY REGISTRAR MAR 18 1982		24b. REGISTRAR'S SIGNATURE [Signature]		

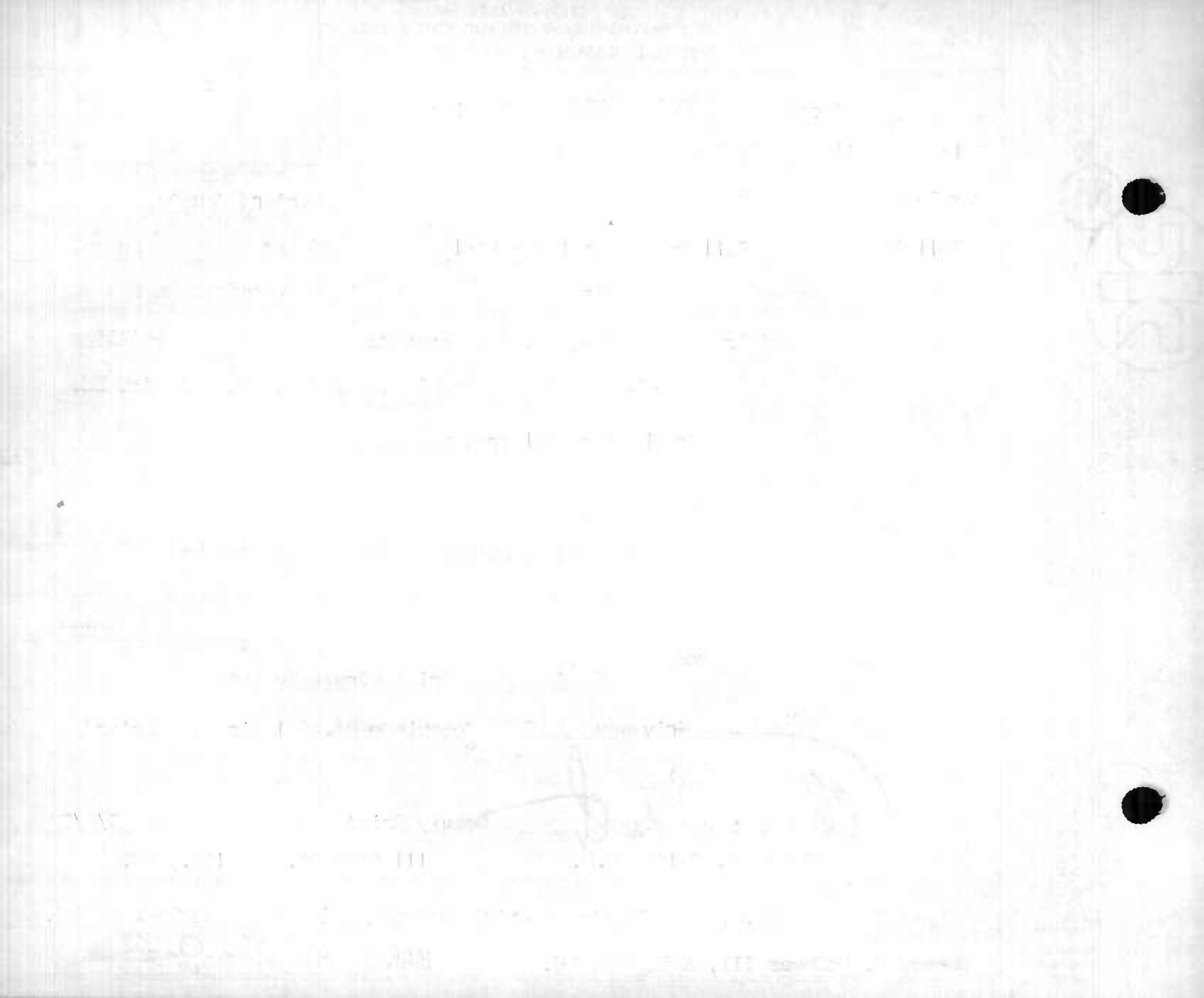
BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 AND 2. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VRA 15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 07311	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Jason Benjamin Brice Hopkins						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 3 5 1982		2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 15, 1976		6. AGE (IN YEARS LAST BIRTHDAY) 5 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 3 5 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD.	
10. CITY OR TOWN OF DEATH Fallston				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY School	
13a. STATE Maryland				13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2234 Conowingo Road	
14. FATHER'S NAME FIRST MIDDLE LAST Carroll McKinley Hopkins, Jr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nanette Fabray Phillips					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 219-88-1871		17. INFORMANT ADDRESS Carroll M. Hopkins, Jr. Bel Air, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio cerebral trauma 8527 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 5:30 P.M. 3 5 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by auto					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) driveway		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2234 Conowingo Rd., Bel Air, Harford, Md					
22a. I certify that I took charge of the remains described above, held death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 3/6/82			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Mar. 9, 1982		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.						25a. DATE REC'D. BY REGISTRAR MAR 8 1982					
						25b. REGISTRAR'S SIGNATURE James J. [Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8207312							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grace Louise Howell						2a. DATE OF DEATH MONTH DAY YEAR 3-31-82		2b. HOUR 10:45 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 11, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. STATE Maryland						13b. COUNTY Harford		13c. CITY OR TOWN Joppa	
14. FATHER'S NAME FIRST MIDDLE LAST David E. Shea						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Luvnia Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-52-7888		17. INFORMANT ADDRESS Forest Hill, Md. Mrs. Bertha L. Cox, 506 E. Jarrettsville Rd.					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Hypertensive intracerebral cardiovascular disease</u> (c) <u>arteriosclerosis, generalized</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>myocardial infarction acute</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
19a. DATE OF OPERATION 2/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 26</u> 19 <u>82</u> , to <u>March 31</u> 19 <u>82</u> , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on <u>March 31</u> 19 <u>82</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Blendley</u> 22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BEN STEY ZA</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 3/31/82			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 3, 1982		23c. NAME OF CEMETERY OR CREMATORY Mountain Christian Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Joppa Harford Md.			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.						25a. DATE REC'D. BY REGISTRAR APR 2 1982		25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>	

1911

1911

1911

1911

1911

1911

1911

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 82 07313	
1. DECEASED NAME (TYPE OR PRINT) Charles Frederick Huber						2a. DATE OF DEATH MONTH DAY YEAR March 22 1982		2b. HOUR 6:39 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 5, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer Ret.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.						13b. COUNTY Harford		13c. CITY OR TOWN Forest Hill			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Huber						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhelmina Albach					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Wife: Clara B. Huber		ADDRESS Forest Hill, Md. 1614 Denise Dr. 21050					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> 4292 DUE TO OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive lung disease - resp. insufficiency</u> DUE TO OR AS A CONSEQUENCE OF (c) <u>Arterio-sclerotic cardiovascular disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>3-19</u> 19 <u>82</u> to <u>3-22</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>3-22</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. YAHAKAWA		22e. ADDRESS M.D. 31956 Union Ave. Havre de Grace Md									
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE Mar 25 1982		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.						25a. DATE REC'D. BY REGISTRAR MAR 24 1982		25b. REGISTRAR'S SIGNATURE James J. Nathan			

MEDICAL CERTIFICATION

Dec. 1917

1917

1917
1917
1917

1917
1917
1917

1917
1917
1917

1917
1917
1917

1917
1917
1917

1917
1917
1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 703-351-1200.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 82 07314			
1. DECEASED NAME (TYPE OR PRINT) CONLEY Cecil HURLEY				2a. DATE OF DEATH MONTH DAY YEAR MARCH 12 82			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 5, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Harks de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator		12b. KIND OF BUSINESS OR INDUSTRY Service Station	
13a. STATE Md 13b. COUNTY Harford 13c. CITY OR TOWN Abingdon				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3633 Abingdon Rd	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Wilson Hurley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Belle May			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1935-1936 218-07-2644		17. INFORMANT ADDRESS Rev. Robert L. Hurley, 600 Maryland Ave, Essex Md. 21221			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST 4100 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ISCHEMIC CARDIOMYOPATHY (c) RECENT MYOCARDIAL INFARCTION							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-3 19 82 , to 3-12 19 82 , that (I) (we) last saw the deceased alive on 3-12 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dante Monakir DEGREE				ATTENDING: <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/12/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIR, M.D.				22e. ADDRESS 622 S. Union Ave Harford Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 15, 1982		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III ADDRESS Abingdon, Md.				25a. DATE REC'D. BY REGISTRAR MAR 15 1982		25b. REGISTRAR'S SIGNATURE Frances Santhorn	

Center of Mass
Wavelength 424
X Wavelength

Mass of particle
Wavelength
Wavelength
Wavelength

Wavelength

Wavelength

Wavelength



Wavelength

Wavelength

Wavelength

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 3 1 5

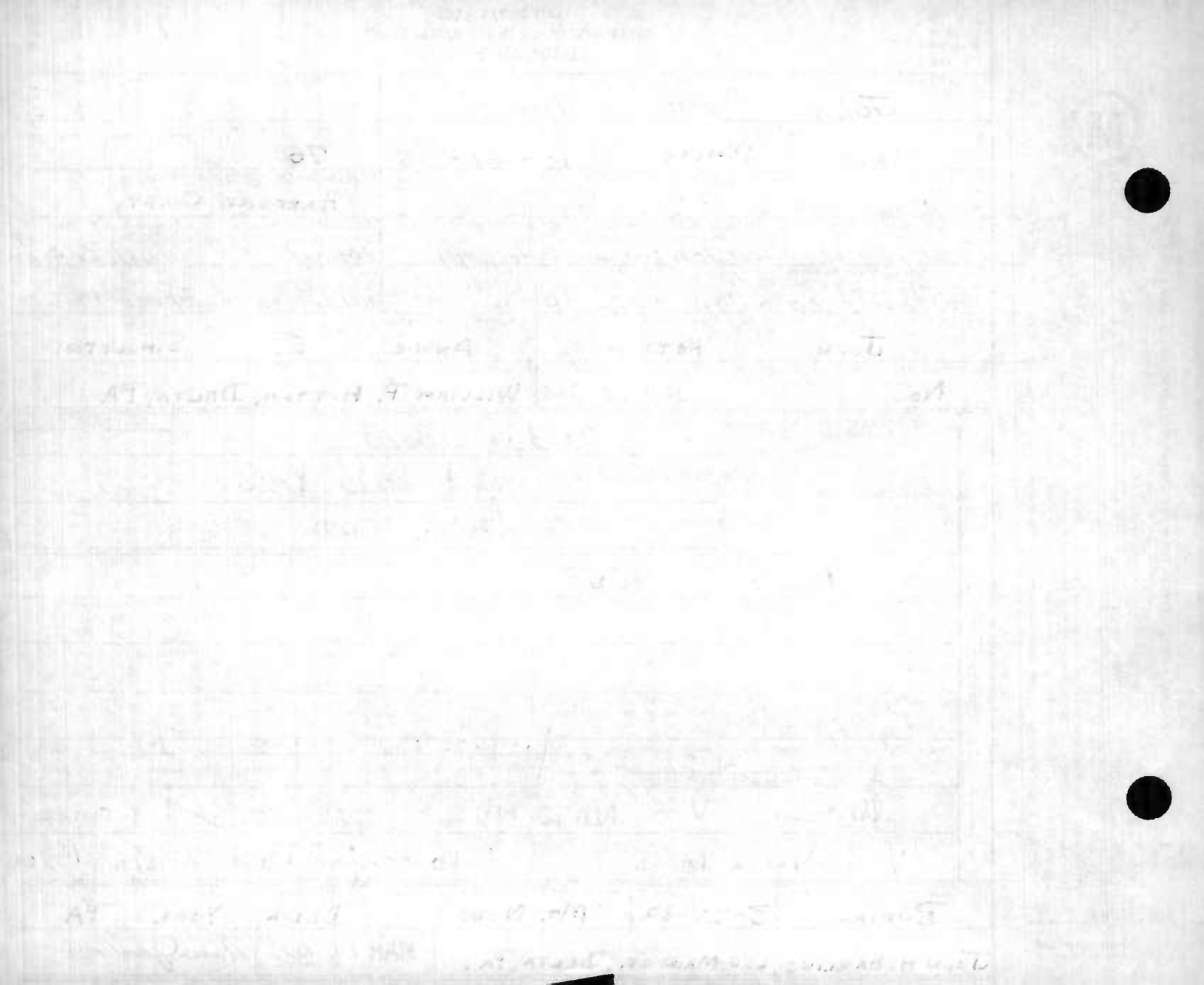
FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John NMN HUTTON			2a. DATE OF DEATH MONTH DAY YEAR 3 22 82			2b. HOUR 4 35 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 - 01 - 05		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania USA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.			
10. CITY OR TOWN OF DEATH Fallston, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Beach Bottom PA.	
13a. STATE 1140 Plaza Ct. Baltimore Co. Joppa, Md.					13b. CITY OR TOWN		13c. STREET ADDRESS 1140 Plaza Ct. Joppa, Md.		
14. FATHER'S NAME FIRST MIDDLE LAST John Hutton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie E. Singleton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 219-12-2234		17. INFORMANT ADDRESS WILLIAM P. HUTTON, DELTA, PA				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) Vent. tach. Prob. DUE TO, OR AS A CONSEQUENCE OF (c) Severe CRO								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DSCVD; HEARD									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/15/82 to 3/22/82, that (I) (we) lost saw the deceased alive on 3/22/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE V-S NAR MD			DEGREE V-S NAR MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/22/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V-S. NAIR M.D.			22e. ADDRESS 1716 Hayford Road; Fallston, MD 2104						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3-25-82		23c. NAME OF CEMETERY OR CREMATORY MT. NEBO		23d. LOCATION CITY OR TOWN COUNTY STATE DELTA YORK PA		
24. FUNERAL DIRECTOR NAME JOHN H. HARKINS, 600 MAIN ST. DELTA, PA.					25a. DATE REC'D BY REGISTRAR MAR 29 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examinations should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edward O. Johnson			2a. DATE KNOWN OF DEATH 3 10 19 82			2b. HOUR M 06		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 3-7-37	6. AGE (IN YEARS) 45 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 3 10 19 82		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD.		
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) M & K. Bus Co.		12b. KIND OF BUSINESS OR INDUSTRY Mechanic
13a. STATE Delaware			13b. COUNTY New Castle	13c. CITY OR TOWN New Castle	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 2 Tavernier Drive		
14. FATHER'S NAME Edward C. Johnson			15. MOTHER'S MARRIEN NAME Esther Alice			16. ADDRESS Esther Johnson-Townsend, Del.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 221-226232			17. INFORMANT ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blunt injury to trunk 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 11:20 P.M. 3 9 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by auto			
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 195 Harford County, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Virginia L. Dolan			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 3-10-82		
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.			ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/13/82		23c. NAME OF CEMETERY OR CREMATORY Townsend Cem.		23d. LOCATION COUNTY STATE Townsend - N.E. Del.		
24. FUNERAL DIRECTOR Robert C. Hutchinson				ADDRESS Middletown, Del.		25a. DATE REC'D. BY REGISTRAR MAR 17 1982		
				25b. REGISTRAR'S SIGNATURE James Jean Nathan				

22

Theresa A. Brown

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MILTON S. KAPINOS						2a. DATE KNOWN OF DEATH ESTIMATED 3-22-82		2b. HOUR M			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 28, 1928-54 YRS.	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 4 11 82		2d. HOUR 3:20 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10. CITY OR TOWN OF DEATH Belcamp		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 7				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Balto. City			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 204 S. Durham St. #21231			
14. FATHER'S NAME FIRST MIDDLE LAST Frank Kapinos				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Pysz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - - - - - 216-24-0402		17. INFORMANT ADDRESS John A. Kapinos- 204 S. Durham St. 21231							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging 9530 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 3-22/29-82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Hanged self.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) woods		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 7 Belcamp Harford Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 4-12-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/16/82		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Harford Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS George A. Weber & Sons Inc.- 705 S. Ann St.				25a. DATE REC'D. BY REGISTRAR APR 18 1982							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

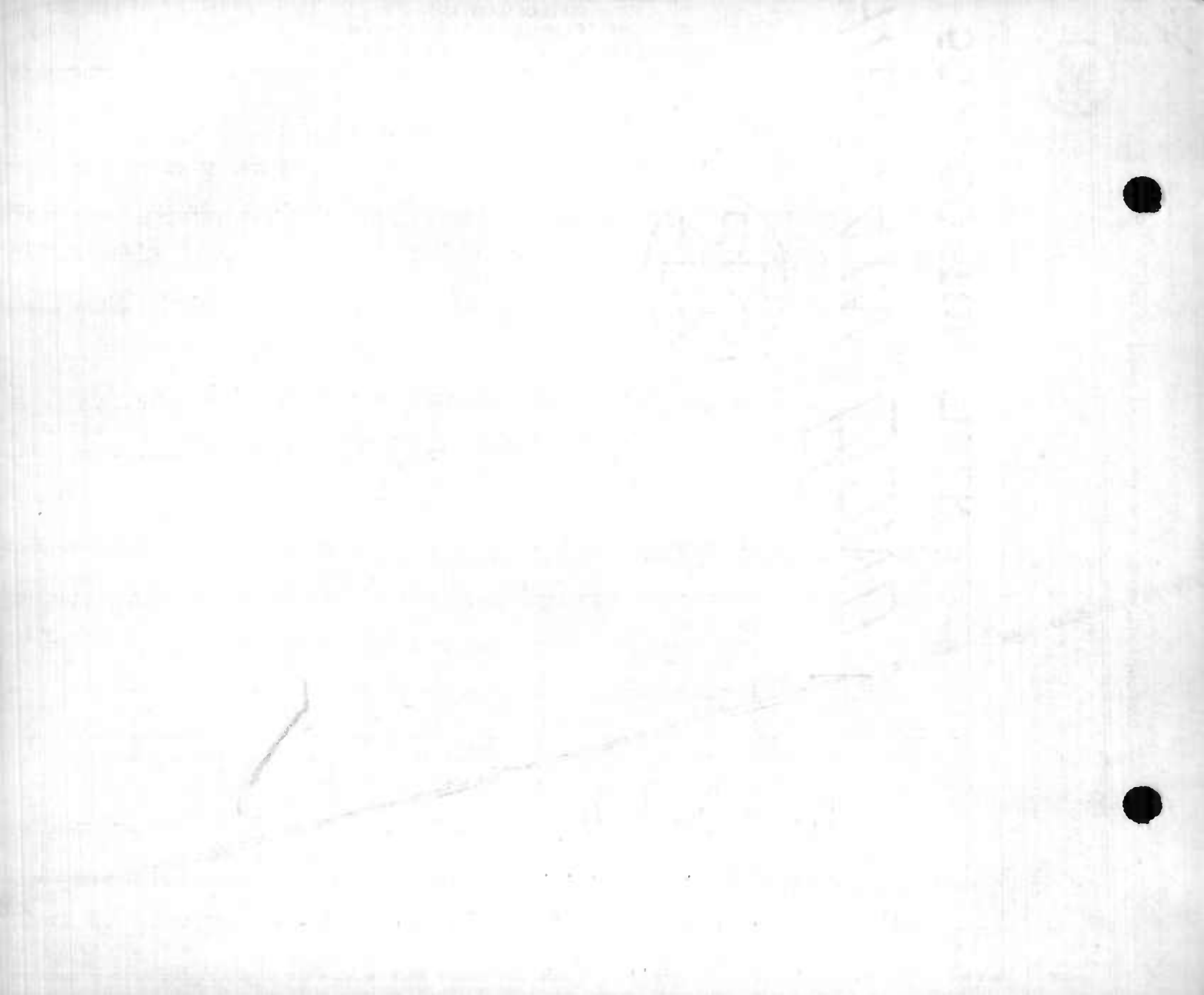
DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOHN D. KEESEE			2a. DATE KNOWN OF DEATH 3-26-82			2b. HOUR 3:28								
3. SEX male	4. RACE white	5. DATE OF BIRTH May 21, 1920	6. AGE (IN YEARS) 61 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 3-26-82	7d. HOUR 3:28								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County								
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction							
13a. STATE Maryland		13b. CITY OR TOWN Harford		13c. CITY OR TOWN Whiteford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1546 Main Street						
14. FATHER'S NAME FIRST MIDDLE LAST Paul M. Keesee			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura A. Perry			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW2 213-16-4947			17. INFORMANT Kenneth E. Keesee, Stillwater, OK		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 3-26-82						
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Mar. 29, 1982		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gdns.				23d. LOCATION CITY OR TOWN COUNTY STATE Aldino Harford Maryland				
24. FUNERAL DIRECTOR NAME John H. Harkins, 600 Main St., Delta, PA						25a. DATE REC'D. BY REGISTRAR MAR 30 1982		25b. REGISTRAR'S SIGNATURE <i>James Van Natta</i>						



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAPERS FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 0 7 3 1 9	
1. DECEASED NAME (TYPE OR PRINT) FRANCIS RAYMOND Kennedy										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 3/14 DAY 19 YEAR 82	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH 7 DAY 9 YEAR 1909	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN 	2c. DATE PRONOUNCED DEAD 3/14 MONTH 19 DAY 82		2d. HOUR 9:30 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Worker		12b. KIND OF BUSINESS OR INDUSTRY Utility				
13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Bel Air 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 204 Idlewild Road											
14. FATHER'S NAME FIRST Edward MIDDLE F. LAST Kennedy				15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE R. LAST Rayan							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) WW II		16b. SOCIAL SECURITY NO. 167-10-1429		17. INFORMANT ADDRESS Mrs. Gail Kennedy Bel Air, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable myocardial infarction 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Samuel H. Henck		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER 721 Wheeler School Rd. Whiteford, Md. 21160		DATE SIGNED 3/15/82					
EXAMINER'S NAME (TYPE OR PRINT) Samuel H. Henck, M.D.		ADDRESS Whiteford, Md. 21160									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/18/82		23c. NAME OF CEMETERY OR CREMATORY Queen Of Heaven Cemetry		23d. LOCATION CITY OR TOWN Peterstownship COUNTY Pa. STATE Pa.					
24. FUNERAL DIRECTOR NAME Marzullo Funeral Services ADDRESS Reisterstown, Md.				25a. DATE REC'D. BY REGISTRAR MAR 18 1982		25b. REGISTRAR'S SIGNATURE James J. Nathan					

Approved: [Signature]

Special Agent in Charge

X

U.S.A.

Department of Justice

Division of Investigation

Washington, D.C.

January 1, 1933

Dear Sir:

Reference is made to your letter of December 28, 1932.

The Bureau has received information that

you are currently conducting an investigation

into the activities of certain individuals

who are alleged to be engaged in

unlawful activities.

The Bureau is interested in the results of your

investigation and would appreciate your

keeping the Bureau advised of any developments.

Very truly yours,

J. Edgar Hoover

Director

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 3 2 0

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ruby Viola Knight			2a. DATE OF DEATH MONTH DAY YEAR March 30, 1982			2b. HOUR 4:20 P.M.	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 8, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hanford County MD.	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS	
13a. STATE Maryland		13b. COUNTY Hanford Co.		13c. CITY OR TOWN Darlington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Stuart		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Plevins		16. SOCIAL SECURITY NO. 217-12-5696			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		17b. SOCIAL SECURITY NO. 217-12-5696		17. INFORMANT (Name) ADDRESS Mrs. Ruth V. Evans 1616 Deerfield Road Darlington, Maryland 21034			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYO CARDIAL INFARCTION 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE (c) 7 YEARS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from 10-13 , 19 64 , to 3-30- , 19 82 , that (II) (we) lost saw the deceased alive on 1-6-82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.							
22b. SIGNATURE Barry J. Plunkett, Jr.				DEGREE M.D.		22c. DATE SIGNED March 31, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry J. Plunkett, Jr., M.D.				22e. ADDRESS 617 West Bel Air Avenue, Bel Air, Maryland 21001			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 2, 1982		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Hanford Co., Maryland 21014	
24. FUNERAL DIRECTOR Joseph William Foster Superior Funeral				25a. DATE REC'D. BY REGISTRAR APR 1 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

BP

Page 1

The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's development.

The second part of the report deals with the economic situation of the country. It is a very interesting and informative study of the country's economic development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's economic development.

The third part of the report deals with the social situation of the country. It is a very interesting and informative study of the country's social development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's social development.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

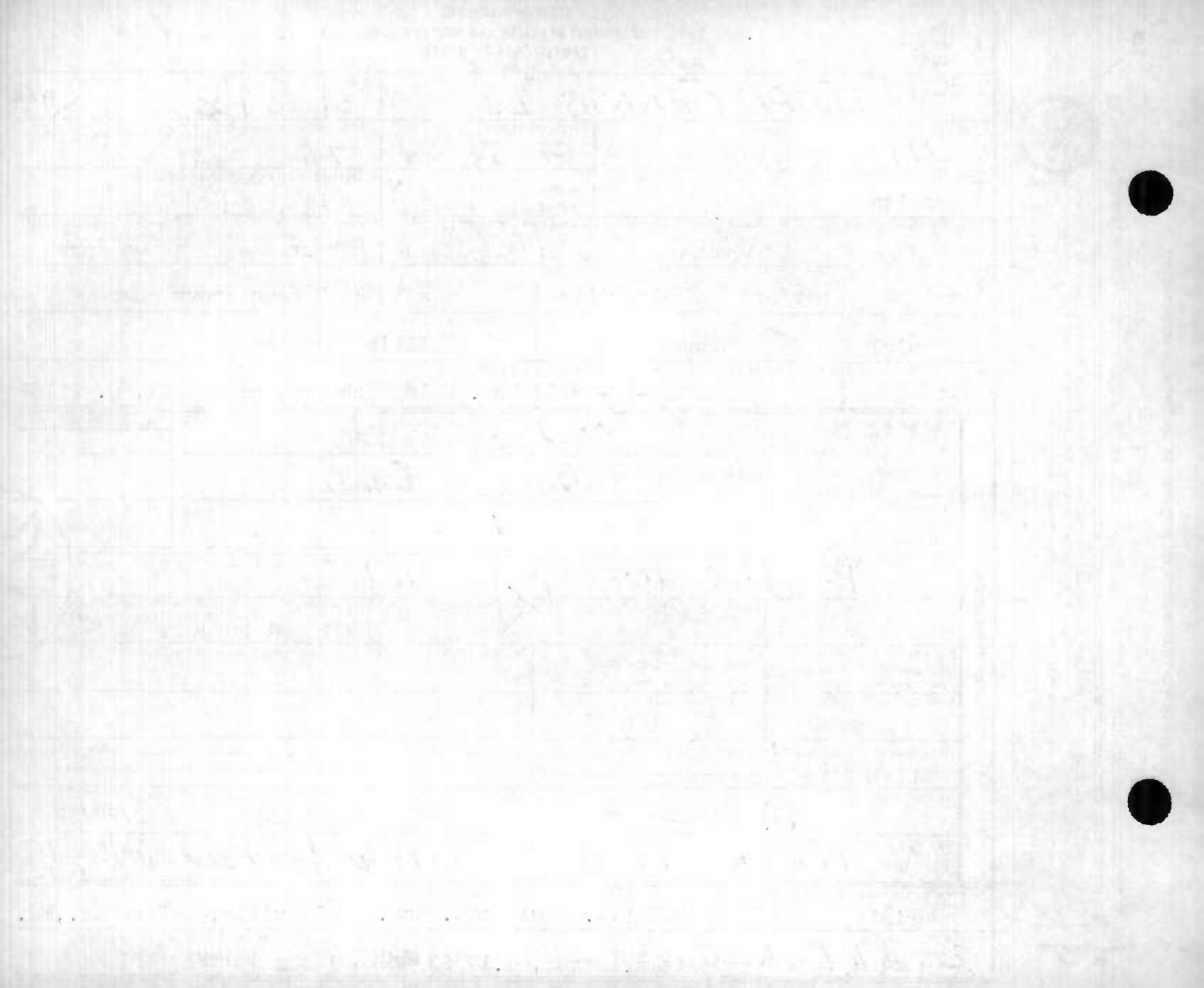
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 0 7 3 2 1			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
LAST FIRST MIDDLE				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) KNOPP, DENNIS L.				2a. DATE OF DEATH MONTH DAY YEAR 3/20/82		2b. HOUR 12:45 PM	
3. SEX M		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01 25 04		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Own Farm	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Pylesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 4900 Fawn Grove Road		14. FATHER'S NAME FIRST MIDDLE LAST Daniel Knopp		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Matthews			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-12-7876		17. INFORMANT ADDRESS Mrs. Lula Kirkwood, White Hall, Md. 21161			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Aneurysm 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Severe CAD. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) A.C.V.D.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Pancreatic thrombosis of emboli.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ame		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/20/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. NAIR M.D.		22e. ADDRESS 1716 Harford Road - Fallston, Md. 21047					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/23/1982		23c. NAME OF CEMETERY OR CREMATORY St. Paul Meth. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Pylesville, Harford Co., Md.	
24. FUNERAL DIRECTOR NAME Kenneth W. Osburn ADDRESS Stewartstown, Pa. 17363				25a. DATE REC'D. BY REGISTRAR MAR 20 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

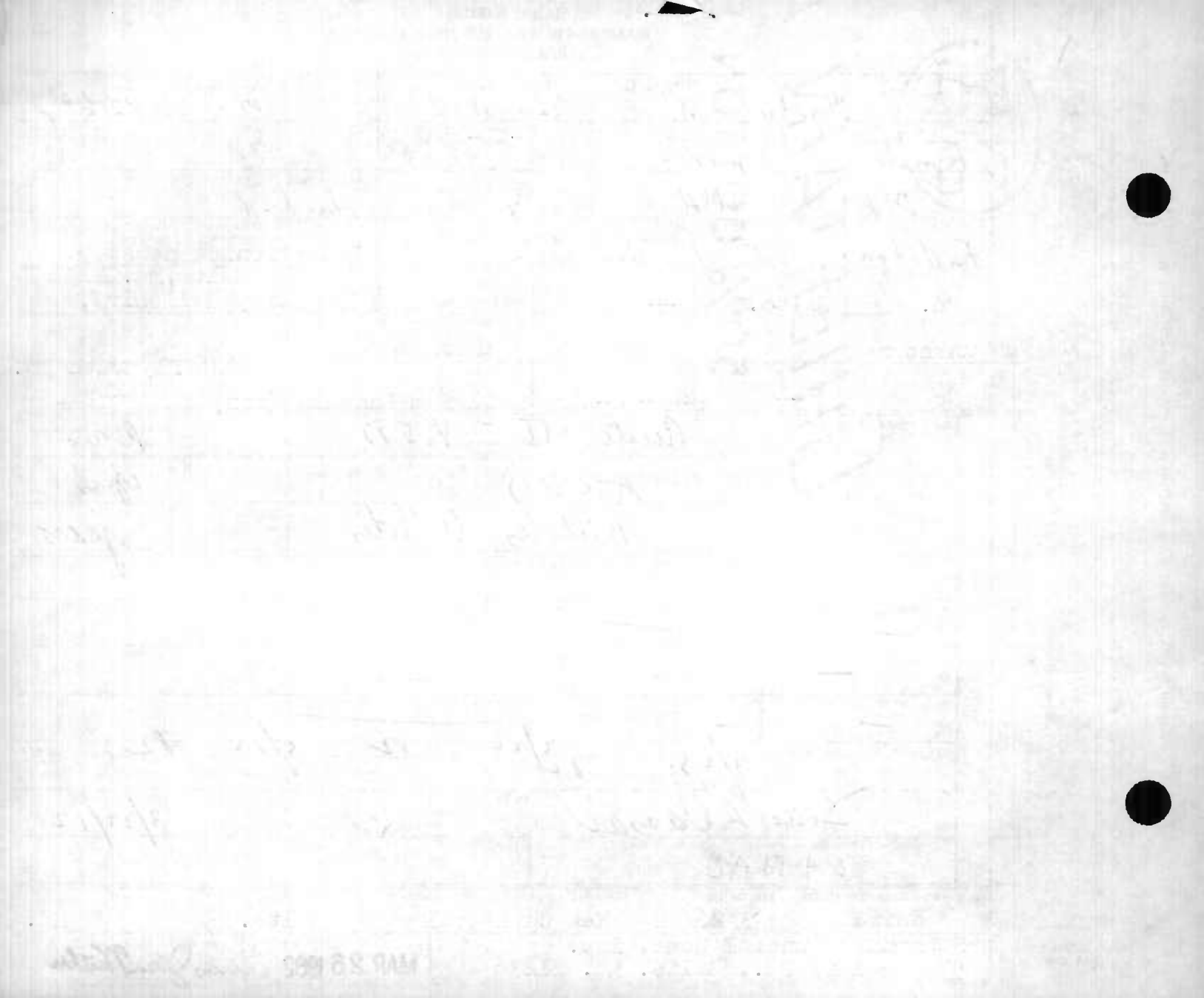
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 3 2 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Myrtle Regina Lanahan Myrtle R. Lanahan			2a. DATE OF DEATH March 23 82 Mar. 23 82		2b. HOUR 6 21 p.m.	
3. SEX Female Female		4. RACE White White		5. DATE OF BIRTH 07-29-03 MONTH DAY YEAR		
6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		8. CITIZEN OF WHAT COUNTRY? USA		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH CASE, GIVE ADDRESS) Fallston Gen Hosp		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Receptionist newspaper		12b. KIND OF BUSINESS OR INDUSTRY		13. BALTIMORE CITY OR COUNTY OF DEATH Md.		
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN ---		
14. FATHER'S NAME FIRST MIDDLE LAST unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown		16. ADDRESS 606 Plymouth Rd. 21229		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No --		16b. SOCIAL SECURITY NO. 220-32-2824		17. INFORMANT William Lanahan (son)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute MI & VSD</u> 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> (c) <u>Diabetes Mellitus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>years</u> <u>years</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.						
19a. DATE OF OPERATION ---		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. LOCATION CITY OR TOWN COUNTY STATE		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>3/23</u> 19 <u>82</u> , to <u>3/23</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>3/23</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Dean L Vassar</u>		22c. ADDRESS DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>3/23/82</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>VASSAR</u>		22e. ADDRESS		22f. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/26/82		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME ADDRESS Schmunk Funeral Home, Inc. 9705 Belair Rd., Balto. Md. 21236		25a. DATE REC'D. BY REGISTRAR MAR 26 1982		25b. REGISTRAR'S SIGNATURE <u>Charles J. Nathan</u>		

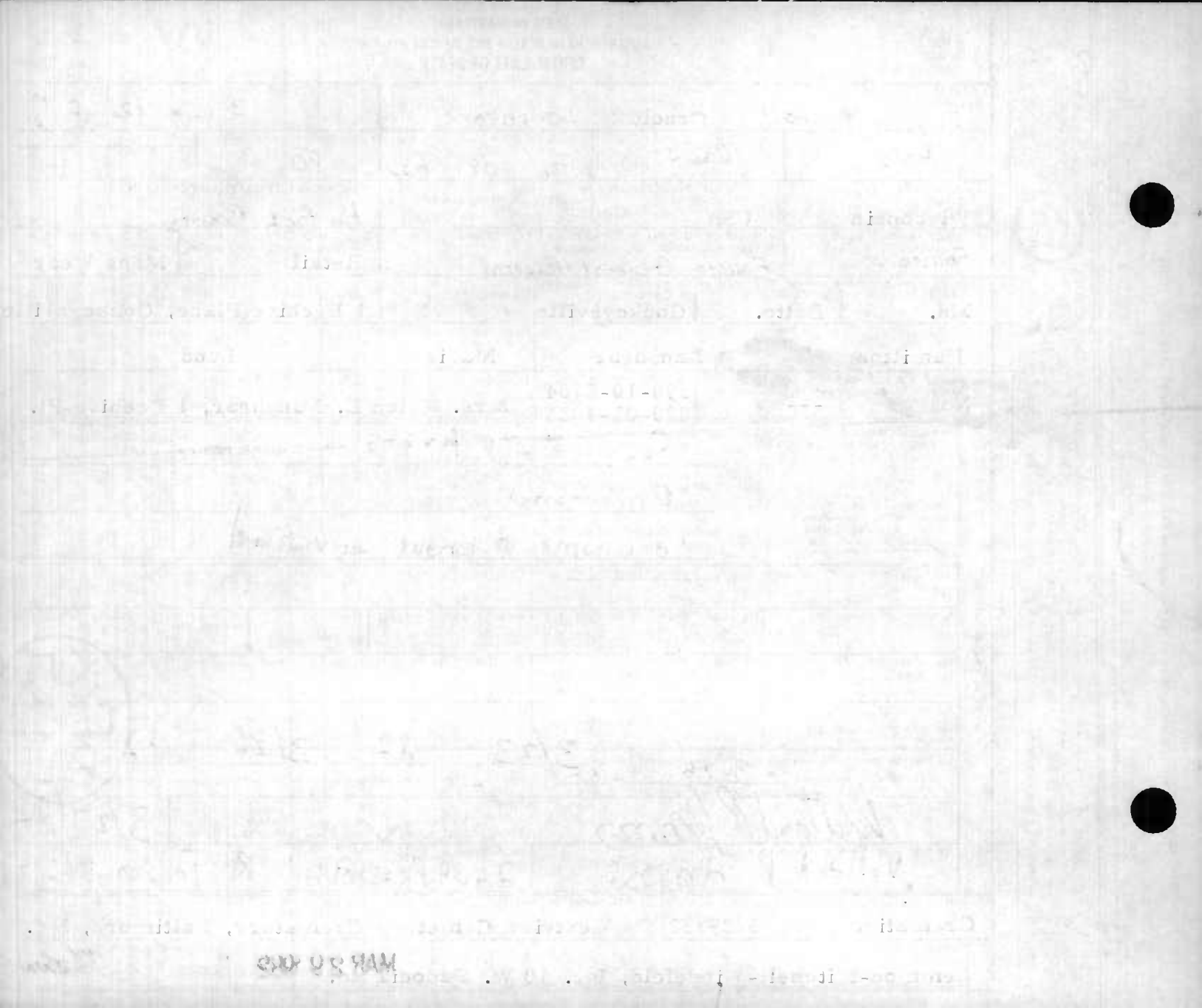


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Marshall Arnold Lanphear					2a. DATE OF DEATH MONTH 3 DAY 26 YEAR 82 HOUR 8:00 PM				
3 SEX Male		4 RACE Cauc.		5. DATE OF BIRTH MONTH 01 DAY 08 YEAR 62		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS 00 DAYS 00 HOURS 00 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford County MD.			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retail		12b. KIND OF BUSINESS OR INDUSTRY Mens Wear	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1 Beehive Place, Cockeysville	
14. FATHER'S NAME FIRST Hamilton MIDDLE Lanphear LAST Lund					15. MOTHER'S MAIDEN NAME FIRST Marie MIDDLE Lund LAST Lund				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 390-10-2734A 820-02-4823		17. INFORMANT ADDRESS Mrs. Helen L. Lanphear, 1 Beehive Pl.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 1419 DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of tongue, advanced APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/23 , 19 82 , to 3/26 , 19 82 , that (I) (we) lost saw the deceased alive on 3/26 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Willard R. Amoss		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/27/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Willard R. Amoss				22e. ADDRESS 2404 Pleasantville Rd, Fallston, MD 21047					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/29/82		23c. NAME OF CEMETERY OR CREMATORY Westview Cemetery/Crematory, Baltimore, Md.		23d. LOCATION CITY OR TOWN Baltimore COUNTY Md. STATE Md.			
24. FUNERAL DIRECTOR NAME Lemmon-Mitchell-Wiedefeld, Inc. ADDRESS 10 W. Padonia Rd.				25a. DATE REC'D. BY REGISTRAR MAR 29 1982		25b. REGISTRAR'S SIGNATURE Charles Van Natten			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the signature of the physician after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SUSAN ELIZABETH LITTLE										2a. DATE OF DEATH MONTH DAY YEAR March 11, 1982		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 16, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.							
10. CITY OR TOWN OF DEATH Darlington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1432 Conowingo Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY School					
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Darlington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1432 Conowingo Road					
14. FATHER'S NAME FIRST MIDDLE LAST Archibald Little				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann E. Main									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No				16b. SOCIAL SECURITY NO. 212-38-4954		17. INFORMANT ADDRESS E. Irene Little, Darlington, Md. 21034							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic shock DUE TO, OR AS A CONSEQUENCE OF (b) Gastrointestinal disease DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 1991 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Rupture Weeks Weeks													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diverticulosis													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Herbert A. Martello						DEGREE M.D.		22c. DATE SIGNED Mar. 12, 1982					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Herbert A. Martello						22f. ADDRESS Whiteford, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Mar. 14, 1982		23c. NAME OF CEMETERY OR CREMATORY Darlington		23d. LOCATION CITY OR TOWN COUNTY STATE Darlington Harford Md.					
24. FUNERAL DIRECTOR NAME John H. Harkins, 600 Main St., Delta, PA						25a. DATE REC'D. BY REGISTRAR MAR 16 1982		25b. REGISTRAR'S SIGNATURE [Signature]					

THE UNIVERSITY OF CHICAGO
LIBRARY
CHICAGO, ILL.

1914

1914

1914

1914

(M)

1914



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMM-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 7 3 2 5					
1. FOR STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
MAY					AMELIA LOVE					03 09 82				9:16 A.M.	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female			White			05 10 86			95 YRS.			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland			USA						Harford MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Bel Air			Bel Air Convalescent Center, Inc.						Homemaker			Housewife			
13a. STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland						Harford		Bel Air		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		142 Williams Street			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME									
Frank McNamee						Alvina Kurrelmeyer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT (Son)		ADDRESS					
No						245-38-0111		Emmett Love, E.		107 Robinwood Road		Galax, Virginia 24333			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO-SCLEROTIC (CARDIO)VASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>OLD AGE</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 16															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) <u>(this hospital)</u> attended the deceased from <u>SEPT 10</u> , 19 <u>78</u> , to <u>MARCH 9</u> , 19 <u>82</u> , that (1) <u>(we)</u> lost saw the deceased alive on <u>JAN 25</u> , 19 <u>82</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>(we)</u> (did) <u>(did not)</u> view the body after death.															
22b. SIGNATURE <u>Philip W. Heuman MD</u> DEGREE										22c. DATE SIGNED <u>MARCH 9, 1982</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PHILIP W. HEUMAN, M.D.</u>										22e. ADDRESS <u>307 HICKORY, BEL AIR, MD 21014</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>March 10, 1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Mch. Cem.</u>				23d. LOCATION CITY OR TOWN <u>Harford Co., Maryland</u> COUNTY <u>Harford</u> STATE <u>Md</u>					
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> <u>Wibroway & Williams St.</u> <u>Bel Air, Maryland 21014</u>															
25a. DATE REC'D. BY REGISTRAR <u>MAR 11 1982</u> 25b. REGISTRAR <u>Harold J. [Signature]</u>															

MEDICAL CERTIFICATION

29

DATE: 03-09-68

TO: [illegible]
FROM: [illegible]

SUBJECT: [illegible]

1. [illegible]
2. [illegible]
3. [illegible]

4. [illegible]
5. [illegible]

6. [illegible]
7. [illegible]

8. [illegible]
9. [illegible]

10. [illegible]
11. [illegible]

12. [illegible]
13. [illegible]

14. [illegible]
15. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 0 7 3 2 6	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <i>Dorothy Jessie Mae Donald</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>March 6, 1982</i>		2b. HOUR <i>10 55</i> M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 22, 1909</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD.					
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Mem Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Res. Manager</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Housing</i>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i> 13b. COUNTY <i>Harford</i> 13c. CITY OR TOWN <i>Bel Air</i>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>605 S. Atwood Rd</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Albert E. Lapka</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Dorothy A. Herbert</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>213-05-8041</i>		17. INFORMANT ADDRESS <i>Mrs. Lorraine M. Staib, 103 Mary Lou Drive, Lothian, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ovarian carcinoma with</i> <i>1830</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized metastases</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>2-15</i> , 19 <i>82</i> , to <i>3-6</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>3-6</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Vicente R. Carag Jr</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/7/82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>V. R. CARAG JR</i>				22e. ADDRESS <i>504 LEWIS ST. HDC MD</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Mar. 8, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cokesbury U.M. Cemetery</i>		23d. LOCATION (CITY OR TOWN) STATE <i>Abingdon Harford Md.</i>					
24. FUNERAL DIRECTOR <i>Howard K. McComas III, Abingdon, Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>MAR 8 1982</i>		25b. REGISTRAR'S SIGNATURE <i>Thames Jan Nathan</i>			

MEDICAL CERTIFICATION

Handwritten notes, mostly illegible due to blurriness. Some words like "Handwritten" and "Notes" are visible.

Handwritten notes, mostly illegible due to blurriness. Some words like "Handwritten" and "Notes" are visible.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 3 2 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) RALPH WAHER McCASLIN				2a. DATE OF DEATH MONTH 3 DAY 16 YEAR 82			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH 6 DAY 29 YEAR 25		6. AGE (IN YEARS LAST BIRTHDAY) (56) 56 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Peters Bridge Maryland (Geor.)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN. HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Transportation	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS 951-Apt. 2 Sablewood Road			
13a. STATE Maryland		13b. COUNTY Harford Co.		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Austin MIDDLE McCASLIN LAST McCASLIN				15. MOTHER'S MAIDEN NAME FIRST AGNES MIDDLE CARR LAST CARR			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes - Army		16b. SOCIAL SECURITY NO. WV 2 216-16-9968		17. INFORMANT (NAME) (Wife) 836-8427 ADDRESS 951-Apt. 2 Sablewood Road Bel Air, Maryland 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4149				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) Severe CHF @ I.H.D.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH 5 DAY 15 YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN VIEW OF PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 5115 CITY OR TOWN Bel Air COUNTY Harford STATE Md.			
22a. I certify that (I) (this hospital) attended the deceased from 5/15 19 82 to 3/16 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body (after death)							
22b. SIGNATURE Joseph A. Reinhardt, M.D. DEGREE ATTENDING PHYSICIAN MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3-16-82			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE March 19, 1982		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	
23d. LOCATION CITY OR TOWN Bel Air COUNTY Harford Co. STATE Maryland				23e. DATE REC'D. BY REGISTRAR MAR 19 1982			
24. FUNERAL DIRECTOR Joseph William Foster ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014				25. REGISTRAR'S SIGNATURE Thane J. [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Helen C. McDonald					2a. DATE OF DEATH MONTH DAY YEAR March 4 1982 2b. HOUR 7:25 AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 4 1903		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.				
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bureau of Internal Revenue		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.					13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William H. Covert					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Booth					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-46-3984		17. INFORMANT ADDRESS Lola Rich, Niece, Same as Above						
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) } 2503 Diabetic mellitus and DUE TO, OR AS A CONSEQUENCE OF } Diabetic nephropathy. (b) } DUE TO, OR AS A CONSEQUENCE OF } Anemia (c) }									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from February 4, 1982, to March 4, 1982, that (I) (we) lost above (b) (c) (d) (did not view the body after death)										
22b. SIGNATURE John P. Yun					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/4/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John P. Yun					22e. ADDRESS Havre de Grace, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-6-82		23c. NAME OF CEMETERY OR CREMATORY Wash. Natl. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland				
24. FUNERAL DIRECTOR NAME Robt E Wilhelm ADDRESS 4308 Suitland Rd., Suitland, Md.					25a. DATE REC'D. BY REGISTRAR MAR 10 1982		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

Handwritten notes at the top of the page, including the date "1892" and some illegible text.

Handwritten notes in the middle section of the page, including the phrase "The first of the year" and other illegible text.

Handwritten notes at the bottom of the page, including the date "1892" and some illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 7 3 2 9			
1. FOR STATE REGISTRAR							
1. DECEASED NAME FIRST MIDDLE LAST MESHACK (nmn) MEADERS x Meadows				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR March 1, 1982 9:17 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 25, 1893 ^R		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stationary Engr.		12b. KIND OF BUSINESS OR INDUSTRY US-govt.Ret.	
13a. STATE Maryland				13b. CITY OR TOWN Harford		13c. STREET ADDRESS 2607 Philadelphia Road	
14. FATHER'S NAME FIRST MIDDLE LAST Major Whitt Meaders				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vicie Keene			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI		17. INFORMANT ADDRESS Mrs. Norma S. Crookshanks, 2615 Phila. Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio vasc. arrest</u> 4149 DUE TO, OR AS A CONSEQUENCE OF <u>ACED. CAR</u> (b) <u>Heart. failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Antonino H. Calon, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Mar. 2, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Antonino H. Calon, M.D.				22e. ADDRESS 1016 Edgewood Road, Edgewood, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 5, 1982		23c. NAME OF CEMETERY OR CREMATORY Cokesbury U.M. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Abingdon Harford	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.				25a. DATE REC'D. BY REGISTRAR MAR 3 1982		25b. REGISTRAR <u>James S. [Signature]</u>	

BP

Order and
Good
for

[Signature]

MAR 8 1982 8 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>A.S.C.D.</u> (c) <u>> 3 years.</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>2-3 months</u> <u>> 3 years.</u>		20. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>① Permanent Demand Pacemaker ② Uremia - renal and pre-renal azotemia</u>		21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		21d. I certify that (I) (this hospital) attended the deceased from <u>3-24</u> 19 <u>82</u> to <u>3-28</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>3-28</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		21e. SIGNATURE <u>Edward C. Loo, M.D.</u>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c. DATE SIGNED		21d. DEGREE M.D.		21e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
21a. PHYSICIAN'S NAME (TYPE OR PRINT)		21b. ADDRESS		21c.					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING;" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John Be Newsome		2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 2b. HOUR <input type="checkbox"/>	
3. SEX Male	4. RACE W.	5. DATE OF BIRTH MONTH 10 DAY 28 YEAR 25	6. AGE (IN YEARS) LAST BIRTHDAY 57 YRS.
7a. BIRTHPLACE (STATE OR COUNTRY) Ky. Ill		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Back Hoe operator		12b. KIND OF BUSINESS OR INDUSTRY Self	
13a. STATE Md		13b. CITY OR TOWN Beech	
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 254 E Red Hill Rd.	
14. FATHER'S NAME FIRST Floyd MIDDLE Newsome LAST Mollie		15. MOTHER'S MAIDEN NAME FIRST Mollie MIDDLE Caude LAST 11	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 403-20 9004	
17. INFORMANT Mary S. Newsome		ADDRESS Same as dec. (wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4149 (b) ASUVD. DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE Luis E Renjel		TITLE (SPECIFY) Deputy MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Luis E RENJEL		ADDRESS 464 Alliance St Harford Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-2-1982	
23c. NAME OF CEMETERY OR CREMATORY Dublin Miss. Baptist		23d. LOCATION CITY OR TOWN Dublin COUNTY Harford STATE Md.	
24. FUNERAL DIRECTOR NAME Richard L Goodie ADDRESS Rising Sun, Md		25a. DATE REC'D. BY REGISTRAR APR 6 1982	
		25b. REGISTRAR'S SIGNATURE [Signature]	

Memorandum
U.S.A.
Date: 10/10/1944
To: Mr. E.A. Tamm
From: Mr. J. Edgar Hoover
Subject: [Illegible]

[Illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 7 3 3 2			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 03 18 82			
1. DECEASED NAME FIRST MIDDLE LAST WALTER HERMAN NIEDERWEMMER				2b. HOUR 8:55 AM			
3. SEX MALE		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 01 08 11		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. 01 09	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? HAFord		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HAFord MD.	
10. CITY OR TOWN OF DEATH FAIRFORD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FAIRFORD GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Gen. Motors	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY HAFord		13c. CITY Joppatowne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST August -- Niederwemmer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine -- (unknown)		13e. STREET ADDRESS 500 Barrington Court Joppatowne, Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-01-7686		17. INFORMANT ADDRESS Mrs. Eileen A. Gann, 500 Barrington Court Joppatowne, Md.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA, SEPSIS 5932 DUE TO, OR AS A CONSEQUENCE OF (b) END STAGE RENAL FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) POLYCYSTIC KIDNEY DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/30 1981 to 3/19 1982 that (I) (we) last saw the deceased alive on 3/18 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Andrew Nowakowski MD		DEGREE		22c. DATE SIGNED 3/18/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew Nowakowski MD	
22e. ADDRESS 125 N. Main St. Bel Air		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					
23b. DATE Mar. 22, 1982		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery, Baltimore		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.		25a. DATE RECEIVED BY REGISTRAR MAR 19 1982		25b. REGISTRAR			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 - 0 7 3 3 3

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DENISE MARY PIASECKI			2a. DATE OF DEATH MONTH DAY YEAR 3-28-82			2b. HOUR 1:02 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 11 53		6. AGE (IN YEARS LAST BIRTHDAY) 29 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY Md. State	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Belair		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 406 Harrington Road	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Frank Piasecki				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa Alvina Kowalezyk					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES) -----		16b. SOCIAL SECURITY NO. 217-62-3085		17. INFORMANT ADDRESS Albert F. Piasecki 406 Harrington Rd. 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ATHEROSCLEROSIS (c) DIABETES MELLITUS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (he) (this hospital) attended the deceased from 3/28 , 19 82 , to 3/28 , 19 82 , that (he) (we) last saw the deceased alive on 3/28 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b. SIGNATURE Andrew Nowakowski DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 5/28/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW NOWAKOWSKI						22e. ADDRESS 125 N. MAIN ST BEL AIR			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-1-82		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery Dundalk, Balto. Co. Md.		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME ADDRESS C.S. Zeiler & Son Inc. 6224 Eastern 7 Avenue						25a. DATE REC'D. BY REGISTRAR MAR 30 1982			
						25. REGISTRAR'S SIGNATURE Thomas J. North			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

BP

DHMH - 16 50M 1/B1
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 3 3 4

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) George Arthur B Pierce			2a. DATE OF DEATH MONTH DAY YEAR 03 14 82			2b. HOUR 3:30 PM				
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 03 14 03		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.				
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Freight Conductor		12b. KIND OF BUSINESS OR INDUSTRY Railroad		
13a. STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Harford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 118 Francis St.	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE A. PIERCE SR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA GRANT SWEINSBURG			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
16b. SOCIAL SECURITY NO. W.W.I.			16c. SOCIAL SECURITY NO. 717-09-2693			17. INFORMANT ADDRESS LEOLA E. LEFFLER, HARFORD, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 4100 DUE TO, OR AS A CONSEQUENCE OF: (b) PROFOUND POSTOP. MYOCARDIAL INFARCTION (c) SEVERE ARTERIOSCLEROTIC CARDIOPULMONARY APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 minutes										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE OR CONDITION GIVEN IN PART 1: SEVERE SA & AV NODAL DISEASE / POST OPERATIVE										
19a. DATE OF OPERATION 11 March 82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CHRONIC CALCULUS CHOLELITHIASIS			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.										
22b. SIGNATURE H. M. Williams MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. M. Williams MD						22e. ADDRESS FGH				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAR. 17 82		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE HARFORD HARFORD MD.			
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA. HARFORD						25a. DATE REC'D. BY REGISTRAR MAR 17 1982		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 7 3 3 5			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret ANNE Pitcock				MONTH DAY YEAR 3 31 82		2b. HOUR 4:45am	
1. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR July 15, 1887		6. AGE (IN YEARS LAST BIRTHDAY) 99	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MD				13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE DE GRACE	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD MANN POWELL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSAN ANNE KEIFER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 213-48-2656		17. INFORMANT ADDRESS CHARLES E. PITCOCK, GLEIV HEIGHTS, MD.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonitis 4860 } DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 56 , to 3/31 , 19 82 , that (I) (we) last saw the deceased alive on 3/30 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE GUNTHER HIRSCH				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-1-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GUNTHER HIRSCH				22e. ADDRESS HAVRE DE GRACE, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPEC) BURIAL		23b. DATE APR. 3, '82		23c. NAME OF CEMETERY OR CREMATORY MOUNTAIN CHRISTIAN CH. 113		23d. LOCATION CITY OR TOWN COUNTY STATE Harford MD.	
24. FUNERAL DIRECTOR Mitchell F.H. PA				25. REGISTERAR'S SIGNATURE HARFORD MD.			

BP

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

REPORT OF SPECIAL AGENT IN CHARGE

Harford County

Chesapeake Nursing Home

State of Maryland

Investigation of

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED



DATE

11/1/82

BY

SA [illegible]

Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 7 3 3 6			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 03 16 82			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eva Theresa Plummer				2b. HOUR 9:00 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 21 98		6. AGE (IN YEARS LAST BIRTHDAY) 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Fallston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Adam Heil		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST N/A Scholastica Rose Kirchner		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 218-07-5503		17. INFORMANT ADDRESS Sybilla Kramer, 124 Briarcliff La, Bel Air					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC TRANSITIONAL CELL CARCINOMA 2349 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>Andrew Nowakowski</u> attended the deceased from <u>3/18</u> , 19 <u>82</u> , to <u>3/16</u> , 19 <u>82</u> , that (I <u>was</u>) last saw the deceased alive on <u>3/12</u> , 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above; (I <u>was not</u>) did not view the body after death.							
22b. SIGNATURE <u>Andrew Nowakowski</u> DEGREE <u>MD</u>				22c. DATE SIGNED <u>March 17, 1982</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Andrew Nowakowski, M.D.</u>	
22e. ADDRESS <u>125 North Main Street, Bel Air, Maryland 21014</u>				23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			
23b. DATE <u>March 19, 1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Bel Air, Harford Co, Maryland 21014</u>			
24. FEDERAL DIRECTOR OF VITAL RECORDS <u>Stephen William Foster</u> ADDRESS <u>W. Broadway & Williams St. Bel Air, Maryland 21014</u>				25. DATE REC'D. BY REGISTRAR <u>MAR 19 1982</u> REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP

9

32

2.150

References

: 0001152

11A 198

[illegible]

1. *Abstract*

Figure 5-1-10

35078

model 5a

[illegible]

2006.

Journal of Management Education

578-56-872

845 10/22/2014 10:00 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at 301-201-1200.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 82 07337									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ., William Henry Plummer					2a. DATE OF DEATH MONTH DAY YEAR 03 12 82					2b. HOUR 1:10 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 04 22 1900			6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD				
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Center, Inc.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saw Mill Operator		12b. KIND OF BUSINESS OR INDUSTRY Lumber		
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Fallston 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 3000 Bel Air Road											
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Frederick Plummer					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Schneider						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-07-5503		17. INFORMANT (NAME, ADDRESS, PHONE NO.) Sybilla Kramer, 124 Briarcliff La. Bel Air, Md. 879-7579							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Upper G.I. Hemorrhage 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Transitional Cell Carcinoma (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 3/8 1982 to 3/12 1982, that (I) (we) last saw the deceased alive on 3/8 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE Andrew Nowakowski MD					DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/12/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW NOWAKOWSKI MD					22e. ADDRESS 125 N. Main St. Bel Air, Md 21014						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 15, 1982		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Co Maryland 21014				
24. FUNERAL DIRECTOR Joseph William Foster Superior Funeral Home					25a. DATE REC'D. BY REGISTRAR MAR 15 1982			25b. REGISTRAR'S SIGNATURE Anne J. [Signature]			

BP

18

COPR SS

2254

554

453

Bel Air Conquest Center, Inc. has 111 owners

note 1509

600/1750

Scenario 3

— — — — —

156-01-1003 Bayville-Kennett, 154 01-01-01 156-01-01-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JOSEPH THOMAS RAINE					2a. DATE OF DEATH MONTH DAY YEAR MARCH 30, 1982			2b. HOUR 3:30 PM			
3. SEX MALE		4. RACE C-WHITE		5. DATE OF BIRTH MONTH DAY YEAR 04 04 07		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.					
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN HOSP				12a. USUAL OCCUPATION (TYPE OF WORK OR TRADE OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Rice Bakery			
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Baldwin		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4301 Sweet Air Road			
14. FATHER'S NAME FIRST MIDDLE LAST Albert Raine					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Flanigen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT Mrs. Bissell E. Raine		ADDRESS 4301 Sweet Air Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic CA (c) Due to, or as a consequence of										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. Reinhardt					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Reinhardt, M.D.					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 2, 1982		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.					25a. DATE REC'D. BY REGISTRAR APR 1 1982		25b. REGISTRAR'S SIGNATURE Frances Santhorne				

Handwritten notes at the top of the page, including the word "HISTORY" and other illegible text.

Main body of handwritten notes, including the phrase "The following is a list of the" and other illegible text.

Handwritten notes at the bottom of the page, including the word "HISTORY" and other illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 7 3 3 9			
1. FOR STATE REGISTRAR							
1 DECEASED NAME FIRST MIDDLE LAST VINNIE E. RITCHIE				2a. DATE OF DEATH MONTH DAY YEAR March 5, 1982		2b. HOUR 10 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 9, 1902		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH 106 Edmund Street HARFORD MD.	
10. CITY OR TOWN OF DEATH Aberdeen		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 106 Edmund Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator - Can		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATISTICAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Aberdeen				13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen	
14. FATHER'S NAME FIRST MIDDLE LAST Frank -- Farnham				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie -- Sawyer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-8212		17. INFORMANT ADDRESS Luther L. Ritchie, 106 Edmund St, Aberdeen Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adenocarcinoma metastatic to Bone</u> 1991 DUE TO, OR AS A CONSEQUENCE OF <u>primary site undetermined</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 21</u> , 19 <u>82</u> , to <u>March 5</u> , 19 <u>82</u> , that (I) <u>was</u> was not saw the deceased alive on <u>March 4</u> , 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> did not view the body after death.							
22b. SIGNATURE <u>B. J. Plunkett Jr</u> M.D.				22c. DATE SIGNED Mar. 5, 1982		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry J. Plunkett, Jr., M.D.	
22e. ADDRESS 617 W. Bel Air Avenue, Aberdeen, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 8, 1982		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.				25a. DATE REC'D. BY REGISTRAR MAR 8 1982		25b. REGISTRAR'S SIGNATURE <u>James J. Plunkett</u>	

Maine

Machine Operator - Can

Sawyer

Luther L. Ritchie, 108 Edmund St.,
Aberdeen, Md.

Government not substantiated
3 mo.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

18A-22a Film G566 4/6/82 rc STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 7 3 4 0	
1. DECEASED NAME (TYPE OR PRINT) Michael Christfer Roycroft										20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 8 1982	
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Dec 25, 1981	6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 2 11	IF UNDER 1 YR. HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD 3 8 1982	2d. HOUR 7:05A				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County		MD.			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Fallston Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE			
12a. STATE Pennsylvania		13. CITY OR TOWN York County		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RD 2, Box 228 (Woodbine Road)					
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Kyle Roycroft		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa Lynn Wilson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT (Name and Address) Mr. Paul F. Burkheimer 615 Gilbert Road Abertown, Maryland 21001							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome 7980 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Hormez R. Guard, M.D.		TITLE (SPECIFY) Assistant				MEDICAL EXAMINER		DATE SIGNED 3/8/82			
EXAMINER'S NAME (TYPE OR PRINT)		111 Penn St. Street, Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 9, 1982		23c. NAME OF CEMETERY OR CREMATORY Mt Zion Meth. Ch. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bal Air, Harford Co., Maryland 21014					
24. FUNERAL DIRECTOR Joseph William Foster		W. Broadway & Williams St. ADDRESS Bal Air, Maryland 21014		25a. DATE REC'D. BY REGISTRAR MAR 11 1982		25b. REGISTRAR'S SIGNATURE Name					

(and other)

and other
and other
and other

and other
and other
and other

and other

and other
and other
and other

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)		FIRST WILLIS	MIDDLE Marvin	LAST SAWYER	2a. DATE OF DEATH		MONTH 3	DAY 6	YEAR 82	2b. HOUR 9 PM
3. SEX Male	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH 3 DAY 27 YEAR 17			6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Dakota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.				
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN. HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR INDUSTRY US-govt. Ret.			
13a. STATE MD.		13b. COUNTY HARFORD		13c. CITY OR TOWN JOPPATOWNE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 127 RAVENWOOD CT.		
14. FATHER'S NAME FIRST MIDDLE LAST Arthur -- Sawyer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angie -- Nelson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII		16b. SOCIAL SECURITY NO. 504-03-27 51		17. INFORMANT ADDRESS Mrs. Dorothy Sawyer, Joppatowne, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Renal failure</u> <u>5712</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alcoholic liver disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cardio Resp. failure. possible Aspiration.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>4-4-1980</u> , 19 <u>82</u> , to <u>3-5</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Feb 1</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.										
22b. SIGNATURE <u>[Signature]</u>				DEGREE MD.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-6-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. PAREKH MD.				22e. ADDRESS 1131 BEL AIR Road, MD 21014						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 10, 1982		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery, Joppa		23d. LOCATION CITY OR TOWN COUNTY STATE Harford Md.				
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.				25a. DATE REC'D. BY REGISTRAR MAR 10 1982		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 7 3 4 2			
1. FOR - STATE REGISTRAR				1. DECEASED NAME FIRST MIDDLE LAST Arthur Cecil Scarborough			
2. DATE OF DEATH MONTH DAY YEAR 3-21-82		2b. HOUR 10 P.M.		3. SEX Male		4. RACE Caucasian	
5. DATE OF BIRTH MONTH DAY YEAR 12-29-91		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford County MD.					
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland		13b. COUNTY Hartford Co.		13c. CITY OR TOWN Street		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Scarborough		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Anna Phantom		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-12-1169	
17. INFORMANT (Name) ADDRESS Mrs. Wilely C. Vaught 1127 Poplar Grove Road Street, Maryland 21154		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>PNEUMONIA, ASPIRATION(?)</u> 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGESTIVE HEART FAILURE</u> (c) <u>CEREBRAL VASCULAR ACCIDENT</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>12/30</u> , 19 <u>81</u> , to <u>3/21</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>3/21</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Andrew Nowakowski MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/21/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW NOWAKOWSKI MD		22e. ADDRESS 125 N. MAIN STREET, BEL AIR, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 23, 1982		23c. NAME OF CEMETERY OR CREMATORY Ascension Episc. Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Street, Hartford Co. Maryland 21154	
24. FUNERAL DIRECTOR Joseph William Foster Superior Funeral		24b. ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014		25a. DATE REC'D. BY REGISTRAR MAR 24 1982		25b. REGISTRAR'S SIGNATURE James J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 2 0 7 3 4 3				
1 DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST Edward Mertz Schilling Sr.					MONTH DAY YEAR 03 25 82				
3 SEX					2b. HOUR				
Male					12:00N				
4 RACE					5. DATE OF BIRTH				
White					MONTH DAY YEAR 02 08 01				
6. AGE (IN YEARS LAST BIRTHDAY)					7. IF UNDER 1 YEAR				
81 YRS					MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?				
Maryland					USA				
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH				
					Harford MD.				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				
Bel Air					Bel Air Convalescent Center, Inc.				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
Production Supv.					Aircraft				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS									
Maryland Harford Joppatowme YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 301 Trimble Road									
14. FATHER'S NAME 15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST FIRST MIDDLE LAST Ferdinand Schilling Hannah Conway									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)									
Yes WWI 21b. SOCIAL SECURITY NO. 21c. INFORMANT ADDRESS									
Yes WWI 214-01-3091 Emma E. Schilling 301 Trimble Road Joppatowme, Md. 21085									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Stricture + Varices Esophagus</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatic Metastasis</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer Colon</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1539</u>									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
P.M. 19									
21d. INJURY OCCURRED 21e. PLACE OF INJURY 21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 1976 to March 1982, that (I) (we) last saw the deceased alive on 3-23-82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE 22c. DATE SIGNED									
William A. Tyson M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 3-25-82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS									
Wm. A. Tyson Box 158 Kingsville Md. 21087									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION									
Burial Mar. 29, 1982 Woodlawn Cemetery Baltimore - Balto - Md.									
24. FUNERAL DIRECTOR 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE									
Howard K. McComas III, Abingdon, Md. MAR 29 1982 Thomas J. Thornton									

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 3 4 4

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bernice C. Schofield			2a. DATE OF DEATH MONTH DAY YEAR March 12, 1982		2b. HOUR 2 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-15-1916		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Abingdon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joe Cullum		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Cullum		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 217-20-9757		17. INFORMANT ADDRESS George D. Schofield - 4905 E. Baker Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Car wrecks 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Car wrecks decomposition (c) Arteriosclerotic brain aneurysm PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Chronic obstructive pulmonary disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 6, 1982 to March 12, 1982 , that (I) (we) lost saw the deceased alive on March 12, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. Yamakawa		DEGREE M.D.		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 3/12/82	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) H. Yamakawa M.D.		22f. ADDRESS 319 So. Union Ave		22g. LOCATION Havre de Grace MD. 21028			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-15-82		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Middle River MD	
24. FUNERAL DIRECTOR NAME John C. Miller Inc.				ADDRESS 6415 Belair Rd. - 21206		25a. DATE REC'D. BY REGISTRAR MAR 15 1982	
				SIGNATURE Frances Sam Martin			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 3 4 5

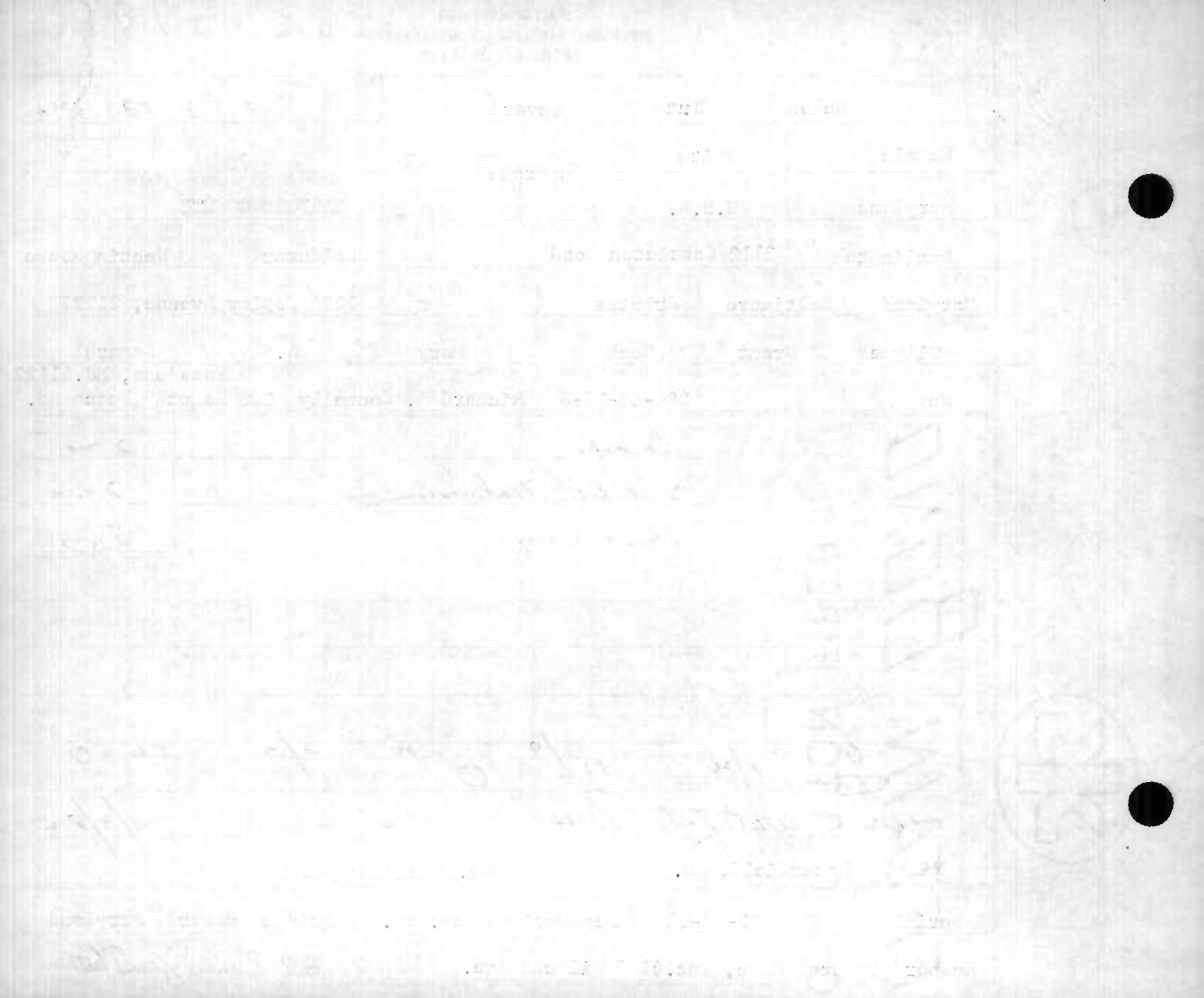
1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Ruth Seward			2a. DATE OF DEATH MONTH DAY YEAR 3 3 82		2b. HOUR 5:30 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 02 22 12		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH Darlington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2112 Castleton Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Solderer		12b. KIND OF BUSINESS OR INDUSTRY Westinghouse
13a. STATE Maryland	13b. CITY OR TOWN Baltimore	13c. CITY OR TOWN Arbutus	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1235 Poplar Avenue, 21227	
14. FATHER'S NAME FIRST MIDDLE LAST Ulysses Grant Cook		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary A. Damerel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-05-3698		17. INFORMANT ADDRESS Pasadena, Md. 21122 Richard B. Connelly 208 Magothy Beach Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cocaine DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mitralatic Malynomy DUE TO, OR AS A CONSEQUENCE OF (c) Beat Comm.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo. 2 yrs 8 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 9/9 , 19 80 , to 3/3 , 19 82 , that (2) (we) last saw the deceased alive on 2/26 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (I) (did) (did not) view the body after death.					
22b. SIGNATURE William Waterfield MD		DEGREE MD		22c. DATE SIGNED 3/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Waterfield, MD.		22e. ADDRESS St. Agnes Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 03-06-82	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR MAR 5 1982	
		25b. REGISTRAR'S SIGNATURE Frances Jean Nathan			

MEDICAL CERTIFICATION

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

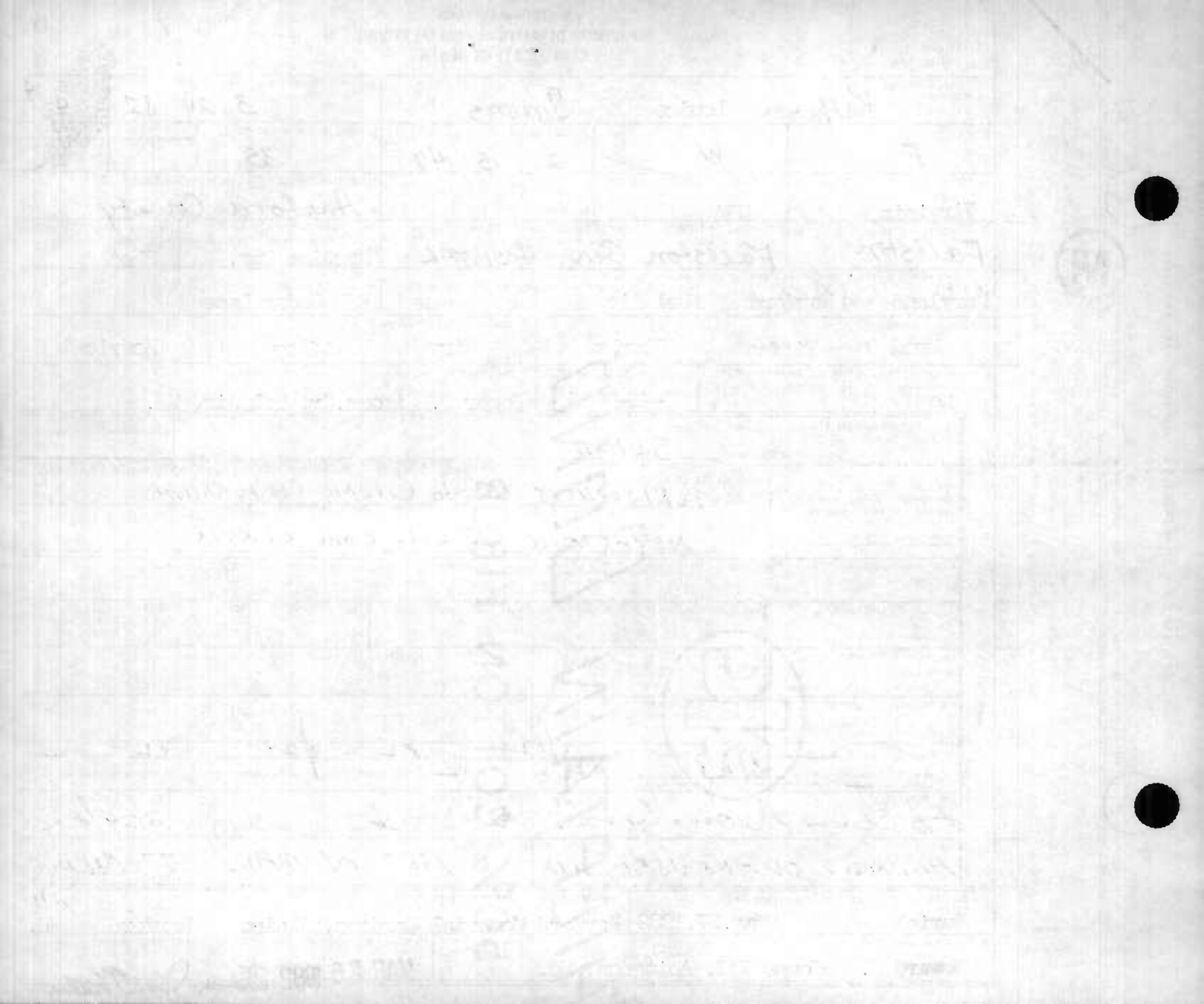
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Kathern Louise Simons					2a. DATE OF DEATH MONTH 3 DAY 24 YEAR 82			2b. HOUR 4:34 M	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH 2 DAY 15 YEAR 47		6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Opr.		12b. KIND OF BUSINESS OR INDUSTRY Shoe	
13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Bel Air					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 809 Cedar Lane		
14. FATHER'S NAME FIRST Fred MIDDLE Tiffen LAST Starks					15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Libby LAST Hedrick				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 269-46-6996		17. INFORMANT ADDRESS Roger D. Simons, Sr. Bel Air, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1809 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: } (b) PERITONITIS 2° to COLONIC PERFORATION } DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC SQ. CELL CARC CERVIX									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH 19 DAY 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/12 19 82 to 3/24 19 82 , that (I) (we) last saw the deceased alive on 3/24 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Andrew Nowakowski DEGREE MD					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/24/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW NOWAKOWSKI MD					22e. ADDRESS 175 N. MAIN ST BELAIR				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 27, 1982		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens		23d. LOCATION CITY OR TOWN Aldino COUNTY Harford STATE Md.		
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.					25a. DATE REC'D. BY REGISTRAR MAR 26 1982 25b. REGISTRAR'S SIGNATURE Frances Van Katten				

BP



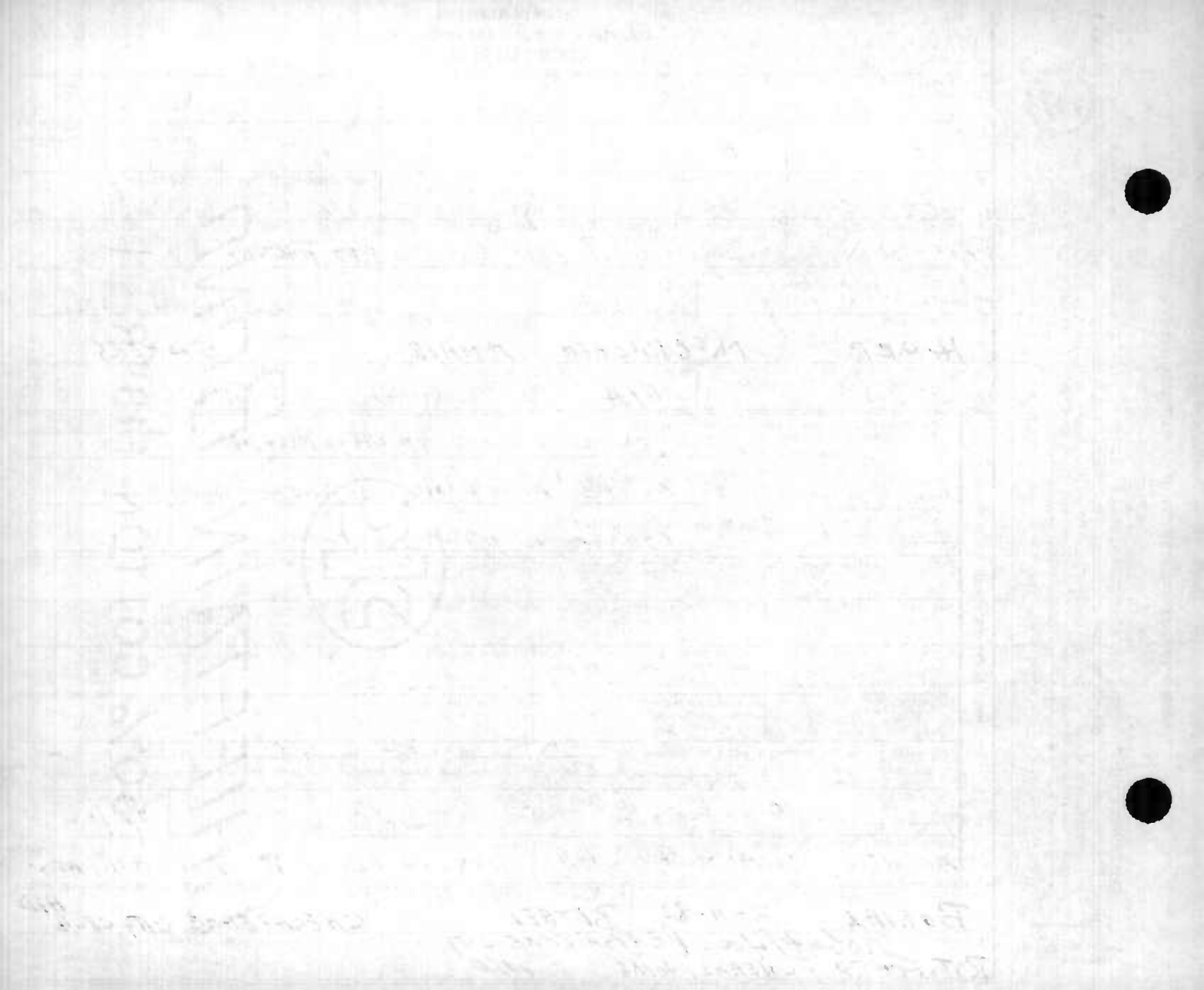
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 82 07347					
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 03 08 82					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL M STEVENS					2b. HOUR 7 A.M.					
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 07 12 14		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? US.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.				
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GEN. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) RET. FACTORY		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY HARFORD		13c. CITY OR TOWN ELKTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 105 FRENCH TOWN ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST HOMER MCCRACKEN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE SAKERS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN			16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS GEORGE STEVENS - ELKTON, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 VENTRICULAR TACHYCARDIA DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE ANTERIOR WALL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ATHEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/7 19 82 to 3/8 19 82, that (I) (we) lost saw the deceased alive on 3/7 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Andrew Nowakowski MD					DEGREE MD		22c. DATE SIGNED 3/8/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW NOWAKOWSKI MD					22e. ADDRESS 125 N. MAIN ST. BGT ATR, MD.					
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 3-11-82		23c. NAME OF CEMETERY OR CREMATORY BETHEL			23d. LOCATION CITY OR TOWN COUNTY CHESAPEAKE CITY CELL MD		
24. FUNERAL DIRECTOR R.T. FORD FUNERAL HOME					25a. DATE REC'D. BY REGISTRAR MAR 10 1982		25b. REGISTRAR'S SIGNATURE			



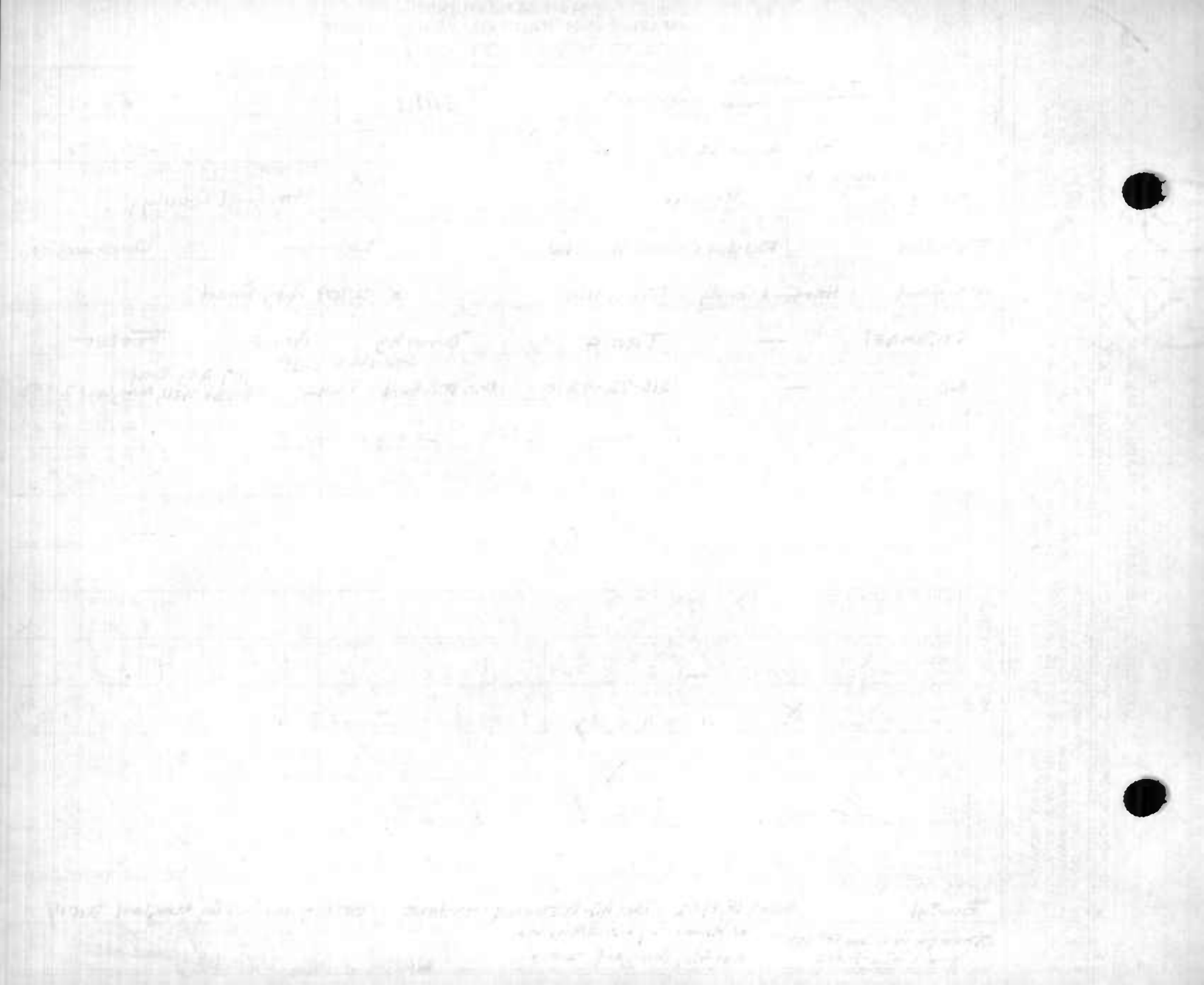
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 7 3 4 8	
1. DECEASED NAME (TYPE OR PRINT) Steven James Tama						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 3-16 1982		2b. HOUR 3:30		2c. DATE OF DEATH 3-16 1982	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 22, 1963		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. 18 YRS.		7c. DATE PRONOUNCED DEAD 3-16 1982		2d. HOUR 2:30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County		10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Construction		13a. STATE Maryland		13b. COUNTY Harford County		13c. CITY OR TOWN Forest Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Michael — TAMA		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy ANNE Forier		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-92-9210		17. INFORMANT (Full name) 838-9235		ADDRESS 2909 Ady Road Forest Hill, Maryland 21050	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain stem injury DUE TO, OR AS A CONSEQUENCE OF (b) Basal skull fracture DUE TO, OR AS A CONSEQUENCE OF (c) Motorcycle accident										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:30am 3-16 1982				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Motorcycle hit a tree			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Highway				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1200 Jarrettsville Rd. Harford Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Samuel H. Henck				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 3/16/82			
EXAMINER'S NAME (TYPE OR PRINT) Samuel H. Henck, M.D.				ADDRESS 721 Wheeler School Rd. Whiteford, Md. 21160							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE March 18, 1982				23c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL GARDENS			
24. FUNERAL DIRECTOR Joseph William Foster				ADDRESS Widenedway & Williams St. Bel Air, Maryland 21014				25a. DATE REC'D. BY REGISTRAR MAR 19 1982			
								25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 3 4 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edward Robert Terwilliger, SR.			2a. DATE OF DEATH MONTH DAY YEAR March 23, 1982		2b. HOUR 11:38 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 23 1899		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Mem Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - Penna. Railroad		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md				13b. COUNTY Hartford		13c. CITY OR TOWN Havre de Grace	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Terwilliger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Linderman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 717-09-3369		17. INFORMANT Keyser Funeral Service, Inc., 326 Albany Ave., Kingston, New York 12401	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac Arrest 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease ? years. DUE TO, OR AS A CONSEQUENCE OF (c) A.S. C.V.D. ? years.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-23 19 82 , to 3-23 19 82 , that (I) (we) lost saw the deceased alive on 3-23 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edward C. Loo, M.D.				DEGREE M.D.		22c. DATE SIGNED 3/24/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. LOO, M.D.				22e. ADDRESS Havre de Grace, Md. 21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial		23b. DATE 24 Mar. 1982		23c. NAME OF CEMETERY OR CREMATORY Wiltwyck Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Kingston Ulster Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399				25a. DATE REC'D. BY REGISTRAR MAR 29 1982		25b. REGISTRAR'S SIGNATURE Thomas J. Matthews	

MEDICAL CERTIFICATION

69 66 35 120 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Edward Scott Thompson

White 11 23 1901
New York U.S.A.

John & Grace Barker from hospital
444 - Hartford Grand Ave
Joseph Thompson Rose

11 23 1901

John & Grace Barker from hospital
444 - Hartford Grand Ave

Joseph Thompson Rose

11 23 1901

John & Grace Barker from hospital
444 - Hartford Grand Ave

Joseph Thompson Rose

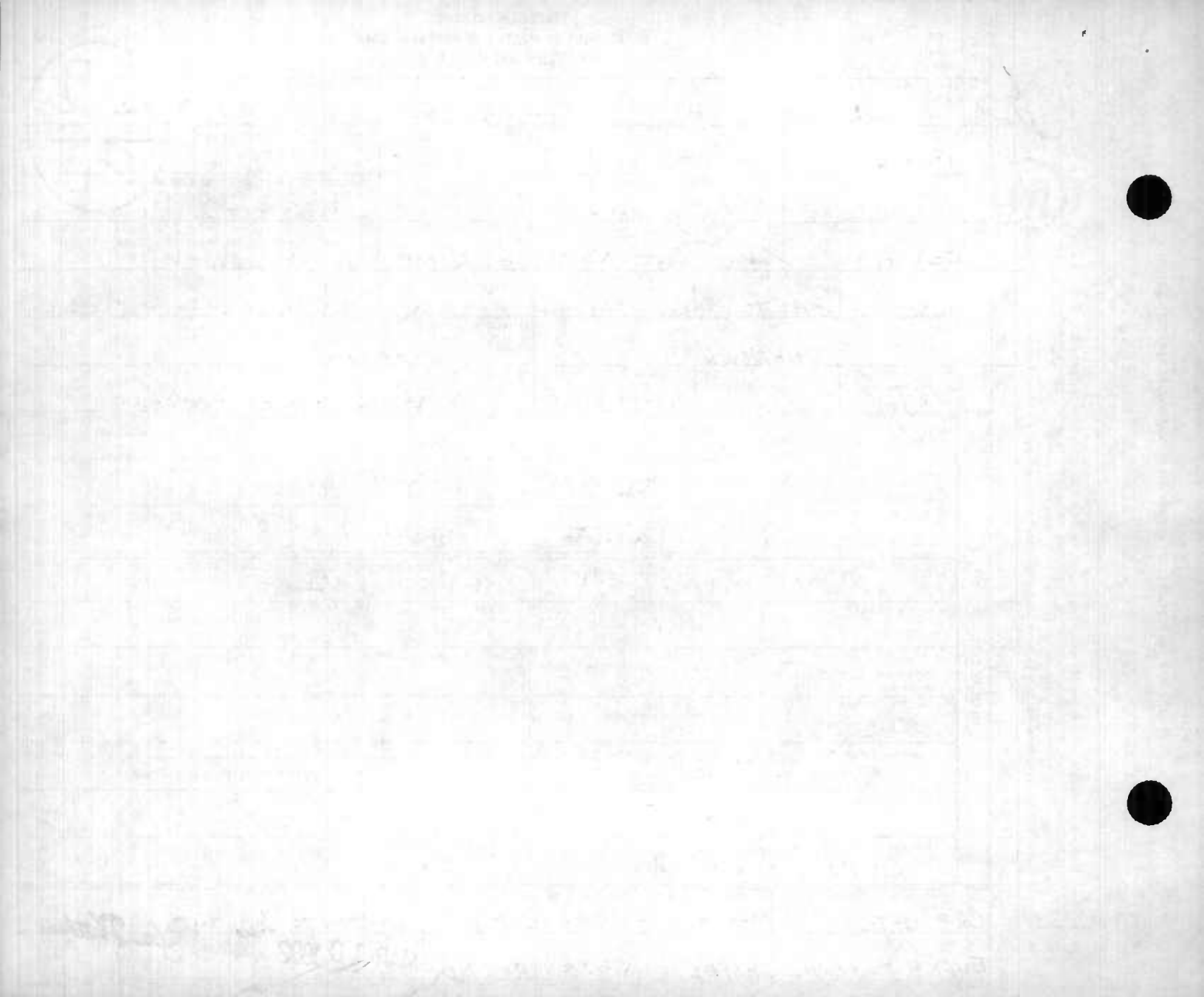
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

3
M
70
BS
30
2
9
9
1

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 7 3 5 0			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Luther H. Townsend						2a. DATE OF DEATH MONTH DAY YEAR 03 3 82				2b. HOUR 6:50 P.M.			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 01 15 25		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD.							
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cabinet maker			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD						13b. COUNTY BALTO.		13c. CITY OR TOWN Long Green		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		13e. STREET ADDRESS 4407 Long Green Rd.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1 217-015640		17. INFORMANT NURSING HOME RECORDS				ADDRESS					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>acute pneumonia, RML & LML</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>concomitant of the lung, left</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN. 20</u> 19 <u>77</u> to <u>MAR 3</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>MAR. 3</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Benedicta</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>MAR. 3/82</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BEN OTEYKA</u>				22e. ADDRESS <u>1131 Baltimore Pike Bel Air, MD 21014</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		23b. DATE <u>MAR. 4, 1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WESTVIEW</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTO. COUNTY MD</u>							
24. FUNERAL DIRECTOR NAME <u>EVANS FUNERAL CHAPEL</u>				ADDRESS <u>9325 YORK RD.</u>				25a. DATE RECEIVED BY REGISTRAR <u>MAR 10 1982</u>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Gertrude		MIDDLE B		LAST Tyler		2b. DATE KNOWN OF DEATH ESTIMATED		MONTH 3		DAY 13		YEAR 1982		2b. HOUR 7:06 P.M.	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11-5-1903		6. AGE (IN YEARS) LAST BIRTHDAY 78 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 13 1982		2d. HOUR 7:06 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD					
10. CITY OR TOWN OF DEATH Fallston				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.				13b. CITY OR TOWN Harford		13c. CITY OR TOWN Fallston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1804 Fallston Rd. 21047							
14. FATHER'S NAME FIRST MIDDLE LAST Henry Smearman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Tresch				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-01-0644 HB					
17. INFORMANT ADDRESS Marilyn R. Madigan - 8194 Gray Haven Rd. 21222				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 Fatal cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Years													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE Samuel H. Henck				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER 721 Wheeler School Rd. 21160				DATE SIGNED 3/13/82					
EXAMINER'S NAME (TYPE OR PRINT) Samuel H. Henck, M.D.				ADDRESS White Ford, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3-17-82		23c. NAME OF CEMETERY OR CREMATORY Pinewood Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.							
24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415				ADDRESS Belair Rd.-21206				25a. DATE REC'D. BY REGISTRAR MAR 15 1982				REGISTRAR Frances J. Nathan					

1-11

Very faint, illegible text spanning the upper half of the page, possibly bleed-through from the reverse side.

Very faint, illegible text spanning the lower half of the page, possibly bleed-through from the reverse side.

Very faint, illegible text at the bottom of the page, possibly bleed-through from the reverse side.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 3 5 2

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Allie Lewis Zellman</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>March 25th 1982</i>		2b. HOUR <i>12:45</i> M	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>SEPT. 10 1917</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>HARFORD Co.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i>			10. CITY OR TOWN OF DEATH <i>Harford Md.</i>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Mem. Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>RET. ENGINEER</i>			
12b. KIND OF BUSINESS OR INDUSTRY <i>PERR POINT HOSPITAL</i>			13a. STREET ADDRESS <i>33 N. EARLTON ROAD</i>			
13b. STATE <i>MD.</i>			13c. CITY OR TOWN <i>HARFORD</i>			
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <i>33 N. EARLTON ROAD</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>FRED ZELLMAN</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARTHA MITCHELL ZELLMAN</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <i>YES W.W.#2</i>			16b. SOCIAL SECURITY NO. <i>214-20-9802</i>			
17. INFORMANT ADDRESS <i>CHRISTINE D. ZELLMAN (SAME)</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia & Septicemia</i> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>RENAL & CONGESTIVE HEART FAILURE</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>3-25-82</i> to <i>3-25-82</i> , that (I) (we) last saw the deceased alive on <i>3-25-82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Leticia S. Galvez</i> M.D.				22c. DATE SIGNED <i>3-25-82</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>LETICIA S. GALVEZ, M.D.</i>				22e. ADDRESS <i>625 S. UNION AVE HARFORD MD</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>MAR 29 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HARFORD MEM. GARDENS</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>MD, 21078</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>MITCHELL FUNERAL HOME - HARFORD MD</i>				
25. DATE REC'D. BY REGISTRAR <i>MAR 26 1982</i>		25. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

